MOUNT CARMEL
6150 East Broad Street • Columbus, Ohio 43213-1574
mountcarmelhealth.com

February 4, 2019

Ms. Pamela J. Para
Center for Medicare & Medicaid Services
Non-Long Term Care Certification & Enforcement Branch
233 North Michigan Avenue
Suite 600
Chicago, Illinois 60601

Re: **Mount Carmel West** **CCN: 36-0035**
793 West State Street
Columbus, Ohio 43222

Dear Ms. Para:

Enclosed is the Plan of Correction addressing the deficiencies cited under Hospital Conditions of Participation 42 CFR 482.25 Pharmaceutical Services based on the survey conducted by the Ohio Department of Health on January 18, 2019.

Thank you reviewing the attached information. If you have any questions or need additional information, please contact me via phone or email.

Sincerely,

Cheryl Wolfe, Regional Director Regulatory Services & Patient Safety Risk Management
Mount Carmel Health System
6150 East Broad Street
Columbus, Ohio 43213
Phone: 614-546-4034
Fax: 614-546-3281
Email: cwolfe@mchs.com

Enclosure:
Signed 2567 Form
Plan of Correction
Policy: Automated Dispensing System-Medication Overrides – Attachment A
Policy: Pharmacist Documentation and Escalation Process – Attachment B
Policy: Palliative Ventilator – Attachment C
Policy: Medication Orders- Attachment D
High Reliability Organization Education – Attachment E

CC: Ohio Department of Health

DEPARTMENT OF HEALTHAND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	360035	A. BUILDING _____ B. WING _____	C 01/18/2019

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A000	INITIAL COMMENTS Substantial Allegation Survey Substantial Allegation OH00102135 On 01/18/19 at 3:45 P.M., an entrance conference was held with administrative staff. During the substantial allegation survey it was determined that an immediate jeopardy existed in the facility when it was identified the facility failed to prevent patients from receiving an overdose of "Central Nervous System (CNS) medications" such as Fentanyl, Versed, Dilaudid, and Morphine. The hospital Administrative Staff was notified of the immediate jeopardy on 01/17/19 at 2:56 P.M. On 01/18/19 at approximately 3:10 P.M., an exit conference was held with the administrative staff, at which time the administrative staff was notified the immediate jeopardy was ongoing. The following deficiencies are based on the substantial allegation OH00102135 completed on 01/18/19. Mt. Carmel West. 360035, is not in compliance with the requirements found at 42 CFR 482, Acute Care Hospital.	A000		
A 489	Condition of Participation: Pharmaceutical Se CFR(s): 482.25 §482.25 Condition of Participation PharmaceuticalServices. The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The	A 489		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Edward A. Bastian — President + CEO

X7: deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 489	Continued From page 1 medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on interview and record review, the hospital failed to ensure a system was in place to monitor and prevent large doses of central nervous system (CNS) medications from being accessed from the automated medication dispensing system (AMDS) by overriding the warnings and prior approval from the pharmacist. This affected 27 (Patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26 and #27) of 27 patient records reviewed. (A491) The failure to prevent patients from receiving a large dose of CNS medications resulted in a determination of immediate jeopardy. The facility census was 186.	A 489		
A 491	PHARMACY ADMINISTRATION CFR(s): 482.25(a) [§482.25 Condition of Participation: Pharmaceutical Services .....The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.] §482.25(a) Standard: Pharmacy Management and Administration The pharmacy or drug storage area must be administered in accordance with accepted professional principles.	A 491		

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A 491	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure a system was in place to monitor and prevent large doses of central nervous system (CNS) medications from being accessed from the automated medication dispensing system (AMDS) by overriding the warnings and prior approval from the pharmacist. This affected 27 (Patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26 and #27) of 27 patient records reviewed. This deficient practice had the potential to affect all patients receiving services at the facility. The facility census was 186. Findings include: 1. Review of a document titled "High Risk CNS Medications", last updated 12/14/18, stated the usual adult dose of Fentanyl was 25 to 100 mcg (micrograms); Dilaudid was one half to four mg (milligrams); and Versed, one half to four mg. 2. Review of the AMDS "override report", undated, provided by Pharmacist D on 01/18/19, revealed 24 of the 27 patients identified had medications dispensed from the AMDS machine with the override function being used. 3. Review of the "Palliative Ventilator Withdrawal-PowerPlan Medication Reference Document", updated 12/14/18, used by the pharmacy revealed the dosage ranges consist of Morphine five to ten mg intravenous (IV) push once, Dilaudid one half to two mg IV push every 15 minutes when needed for shortness of breath, and Versed two mg IV push once as soon as possible. Fentanyl was not listed on this	A 491		

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A 491	Continued From page 3 document as a medication to use for palliative ventilator withdrawal. 4. Review of the facility policy titled "Physician Orders" revealed verbal or telephone orders are to be limited and restricted to: a. emergent situations b. When clinical situations make it impractical for orders to be entered into the Electronic Health Record (EHR) or written on the appropriate form for the non-EHR cites. c. Situations when physicians do not have access to remote computer devices or the patient's chart. 5. Review of the facility palliative care policy/procedure, titled "Palliative Ventilator Withdrawal", dated 05/26/17, stated "palliative ventilatory withdrawal is the provision of comfort measures for a seriously ill patient for whom continuing mechanical ventilation has been determined to be clinically inappropriate or unwanted by the patient." Under "Implementation of Symptom Management Medication orders" it stated "symptom management medications will be ordered as medically indicated". 6. During interview on 01/16/19 at 4:10 P.M., Physician B stated there was no current "lock out" on the AMDS machine to prevent staff from continuing to override the system to obtain medications. 7. During interview on 01/17/19 at 3:15 P.M., Pharmacist A (chief pharmacy officer) was unable to offer any information explaining how staff had	A 491		

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A 491	Continued From page 4 been able to override the AMDS system for a long period of time to obtain high doses of CNS medications with no pharmacy approval or intervention. 8. Review of the medical record for Patient #1 revealed the patient presented to the facility on 09/10/18 with increasing shortness of breath. Review of Physician A's progress note, dated 09/18/18 at 2:54 A.M., revealed Physician A was called to Patient #1's bedside by nursing staff for code status discussion. Patient #1 stated "I am done and don't want to suffer anymore". Physician A explained the options of aggressive treatment versus comfort measures. Patient #1 clearly stated that he did not want to suffer and wanted to be comfortable. On 09/18/18 at 4:04 A.M., Physician A gave a verbal order for Dilaudid four mg IV push, which was administered at 4:04 A.M. A second verbal order was received for Dilaudid six mg IV push, which was administered at 4:33 A.M. Physician A pronounced Patient #1 dead at 5:00 A.M. 9. Review of the medical record for Patient #2 revealed the patient presented to the facility with generalized weakness and confusion on 11/25/17. A physician note dated 12/11/17 at 2:48 A.M. revealed a "code blue" (cardiac/respiratory emergency) was called; Patient #2 was intubated at that time, placed on a ventilator and transferred to the intensive care unit (ICU). Review of Physician A's progress note, dated 12/11/17 at 4:17 A.M., revealed Patient #2 was readmitted to the ICU for cardiac arrest and was intubated during a code blue. Physician A documented the patient's family was updated at the bedside regarding events and decided to withdraw care. At 5:10 A.M., Physician A gave a verbal order for	A 491		

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A 491	Continued From page 5 Fentanyl 1,000 mcg IV push. The order was verified by the pharmacist at 5:14 A.M. This medication was dispensed from the AMDS via override and administered at 5:45 A.M. Patient #2 was pronounced dead by Physician A at 6:03 A.M. There was no documentation in the medical record stating when Patient #2 was removed from the ventilator. 10. Review of the medical record for Patient #3 revealed the patient presented to the facility on 03/11/17 with altered mental status. Review of a physician progress note dated 03/11/17 at 1:02 P.M. revealed Patient #3 was intubated in the emergency room with agonal breathing. Physician A's progress note, dated 03/11/17 at 10:58 P.M., revealed a meeting was held at the bedside with the the patient's family and the family wished to withdraw care. Physician A entered an order for Fentanyl 400 mcg IV push for agitation on 03/11/17 at 10:13 P.M. The order was verified by the pharmacist at 10:18 P.M. The medication was dispensed from the AMDS and administered at 10:36 P.M. The physician stated all blood pressure medications were stopped, the patient was extubated and died at 10:50 P.M. 11. Review of the medical record for Patient #4 revealed the patient presented to the facility on 07/18/16 at 6:06 P.M. for cardiac arrest at a long term care facility and was intubated in the field. The nursing progress note dated 07/25/16 at 8:05 P.M. revealed Physician A spoke to the spouse of Patient #4 over the phone about changing the patient's code status to do not resuscitate. A physician progress note dated 07/25/16 at 10:11 P.M. revealed at 9:45 P.M., the patient's spouse made the decision to extubate the patient. At 9:46 A.M., Physician A gave a verbal order for	A 491		

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A 491	Continued From page 6 Fentanyl 400 mcg IV push. The AMDS system was overridden and the Fentanyl was administered at 9:46 P.M. At 9:47 P.M., Patient #4 was extubated. At 9:50 P.M., medication to support blood pressure was stopped. Patient #4 was pronounced dead at 10:06 P.M. 12. Review of the medical record for Patient #5 revealed the patient presented to the facility on 02/10/15 for septic shock. Review of Physician A's progress note dated 02/11/15 at 2:32 A.M. revealed Physician A explained the grave situation to Patient #4's family members, and after considering all options, the patient's family decided on "palliative ventilator withdrawal". Physician A ordered Fentanyl 400 mcg IV push and Versed 4 mg IV push at 12:41 A.M. These orders were verified by a pharmacist at 12:42 A.M. The medications were dispensned from the AMDS via override and given at 1:05 A.M. Patient #4 was pronounced dead at 1:07 A.M. 13. Review of the medical record for Patient #6 revealed the patient presented to the facility on 04/22/15 for a seizure. A physician progress note dated 05/10/15 revealed the patient's family decided to withdraw care. On 05/10/15 at 11:23 P.M., Physician A ordered Fentanyl 1,000 mcg IV push. The AMDS system was overridden and the medication was dispensed at 11:24 P.M. The pharmacy verified the order at 11:24 P.M. stating the medication was compliant with standard treatment. The Fentanyl was administered at 11:32 PM. Medications to support blood pressure were stopped and the patient was extubated. Patient #6 was pronounced dead at 11:40 P.M. 14. Review of the medical record for Patient #7 revealed the patient presented to the facility on	A 491		

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A 491	Continued From page 7 04/30/15 for progressive weakness followed by a fall. A nursing progress note dated 05/04/15 stated that at 11:28 P.M., Patient #4's cardiac monitor showed asystole (absence of a heartbeat). At that time, Patient #4 was given Dilaudid 0.5 mg IV push for comfort. Patient #4 still had agonal breathing at which point Physician A ordered Fentanyl 500 mcg IV push. On 05/03/15 at 11:57 P.M. a telephone order for Fentanyl 500 mcg IV push was placed. The medication was dispensed via override and given at 11:57 P.M. The order was verified by a pharmacist at 11:59 P.M. The patient's family arrived at 12:05 A.M. Physician A ordered Fentanyl 400 mcg IV push due to agonal breathing. On 05/04/15 at 12:10 A.M., a telephone order for Fentanyl 400 mcg IV push was placed. The medication was dispensed via override and administered at 12:10 A.M. The order was verified by a pharmacist at 12:22 A.M. Patient #4 was pronounced dead by Physician A at 12:30 A.M. 15. Review of the medical record for Patient #8 revealed the patient presented to the facility on 02/28/15 with a change in mental status. The patient was diagnosed with a multi-embolic stroke with brain stem involvement. While in the emergency room, Patient #8 went into respiratory arrest and was intubated. Physician A's progress note dated 03/01/15 at 12:47 A.M. stated the family wished to pursue "palliative ventilator withdrawal". The patient had a physician order dated 03/01/15 at 12:11 A.M. for Fentanyl 800 mcg IV push. The AMDS system was overridden and the medication was administered at 12:11 A.M. The patient was extubated at 12:11 A.M. and Patient #8 was pronounced dead at 12:42 A.M. The pharmacy verified the order at 1:19	A 491		

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A 491	Continued From page 8 A.M. 16. Review of the medical record for Patient #9 revealed the patient presented to the facility on 09/30/17 for suspected chronic heart failure and had been intubated in the ICU that same day. On 10/09/17 at 8:24 P.M., a telephone order from Physician A was obtained for Fentanyl 1,000 mcg. A pharmacy note stated Physician A entered an order for 1,000 mcg of Fentanyl IV push for a morbidly obese patient that had been on high dose narcotic drips on whom care was being withdrawn. The pharmacist discussed with Physician A that Fentanyl was on shortage and recommended a dose of 500 mcg. The physician agreed. The nursing note stated the patient was taken off the ventilator on 10/09/17 at 9:00 P.M. with the patient's family at the bedside. Fentanyl 500 mcg was dispensed from the AMDS system via override and given at 9:03 P.M. Physician A's progress note documented Patient #9 died at 9:10 P.M. 17. Review of the medical record for Patient #10 revealed the patient presented to the facility on 10/02/17 due to a coughing spell that lead to finding of probable bronchogenic cancer. The discharge summary documented the patient had a liver biopsy done on 10/09/17. Shortly after the biopsy, the patient developed a small hematoma. In a few hours, the patient's blood pressure dropped and the patient went into cardiac arrest. Patient #10 was intubated and transferred to the ICU. On 01/09/17 at 10:22 P.M. a telephone order was placed for Fentanyl 500 mcg IV push and Versed four mg IV push. The nursing progress note documented the patient was removed from the ventilator at 11:20 P.M. Review of the medication administration record	A 491		

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A 491	Continued From page 9	A 491		

revealed both medications were dispensed from the AMDS via override and administered at 11:34 P.M. Review of the physician progress note revealed the patient died at 11:34 P.M.

18. Review of the medical record for Patient #11 revealed the patient presented to the facility on 10/06/17 due to acute brain swelling and respiratory failure. The patient required emergency intubation. On 10/11/17 at 4:01 A.M., a verbal order was obtained for Fentanyl 500 mcg IV push. At 4:02 A.M., the AMDS system was overridden and the Fentanyl was dispensed. On 10/11/17 at 4:05 A.M. Versed six mg was dispensed from the AMDS system via override. The physician didn't enter the order until 4:11 A.M. The medication administration record documented the Versed was administered at 4:11 A.M. and the Fentanyl was administered at 4:12 A.M. Patient #11 was extubated at 4:12 A.M. and was pronounced dead at 4:19 A.M.

19. Review of the medical record for Patient #12 revealed the patient presented to the facility on 11/12/18 due to sepsis. On 11/20/17 at 8:13 P.M., a physician n order for Fentanyl 500 mcg IV push was entered into the system. The order was verified by the pharmacy at 8:22 P.M. and dispensed from the AMDS system at 8:23 P.M. The medication administration record documented the medication was given at 8:28 P.M. The patient was extubated at 8:34 P.M. Patient #12 died at 10:40 P.M.

20. Review of the medical record for Patient #13 revealed the patient presented to the facility on 12/05/17 at 12:15 P.M. due to unresponsiveness related to having low blood pressure. In the emergency room, Patient #13 was intubated and

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A 491	Continued From page 10 placed on a ventilator. On 12/05/17 at 9:23 P.M., a physician order for Fentanyl 1,000 mcg IV push was entered and at 9:40 P.M., an order for Dilaudid 2 mg IV push was entered. At 9:40 P.M., a verbal order for Versed four mg IV push was entered. Fentanyl 1,000 mcg was dispensed from the AMDS with override at 9:27 P.M.; Dilaudid 2 mg was dispensed with override at 9:35 P.M.; and Versed was dispensed with override at 9:34 P.M. The medication administration record documented the Fentanyl was administered to the patient at 9:37 P.M. Patient #13 was extubated at 9:39 P.M. Dilaudid and Versed were administered at 9:40 P.M. Physician A's progress note revealed Patient #13 was pronounced dead at 9:41 P.M. 21. Review of the medical record for Patient #14 revealed the patient presented to the facility on 12/10/17 at 5:47 P.M. due to altered mental status related to a history of cancer. Physician A's progress note dated 12/10/17 at 8:52 P.M. stated that the decision to intubate was made to hyperventilate Patient #14 to compensate for extreme acid base imbalance of the blood. Physician A's progress note dated 12/10/17 at 11:11 P.M. stated the patient's grim prognosis was discussed with the family at the bedside and the family agreed to withdraw care. Review of the physician orders revealed telephone phone orders entered by nursing staff on 12/10/17 at 10:34 P.M. for Fentanyl 500 mcg and Versed four mg IC push. The medications were dispensed from the AMDS system with override at 10:12 P.M. The medication administration record documented the Fentanyl was administered at 10:36 P.M. and the Versed was administered at 10:36 P.M. Patient #14 was pronounced dead at 10:41 P.M. There was no documentation in the	A 491		

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A 491	Continued From page 11 medical record stating when the patient was extubated and taken off the ventilator. 22. Review of the medical record for Patient #15 revealed the patient presented to the facility on 11/15/18 due to difficulty breathing. On 11/19/18, the patient was transferred to the ICU for further monitoring. On 11/20/18 at 8:11 P.M., the patient was intubated and placed on a ventilator. The nursing progress note dated 11/20/18 at 11:15 P.M. documented the patient's family requested "palliative ventilator withdrawal" at 11:48 P.M. Fentanyl 1,000 mcg was dispensed from the AMDS via override at 11:28 P.M. and 11:30 P.M. and Versed 10 mg had been dispensed via override at 11:29 P.M. Review of the physician orders revealed orders at 11:48 P.M. for Fentanyl 2,000 mcg IV push and Versed 10 mg. The medication administration record documented Fentanyl 2,000 mcg IV push was administered at 11:48 P.M. and Versed 10 mg IV push was administered at 11:49 P.M. Patient #15 was pronounced dead at 11:53 P.M. There was no documentation in the medical record stating when the patient was extubated and taken off the ventilator. 23. Review of the medical record for Patient #16 revealed the patient presented to the facility on 11/13/18 due to increased difficulty breathing. After a cardiac catheterization on 11/15/18, the patient developed an enlarging right groin blood clot. The patient was transferred to the ICU and intubated on 11/16/18 related to low blood oxygen levels. Review of the physician orders revealed on 11/19/18 at 12:54 A.M., Physician A ordered Fentanyl 1,000 mcg and Versed 10 mg IV push. The Fentanyl was dispensed from the AMDS at 12:55 A.M. and the Versed was dispensed at	A 491		

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	360035	A. BUILDING _____ B. WING _____	C 01/18/2019

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A 491	Continued From page 12 12:56 P.M., both via override. The medication administration record documented both the Fentanyl and the Versed were administered at 1:26 A.M. Patient #16 was pronounced dead at 1:32 A.M. Physician A's progress note, dated 11/19/18 at 1:51 A.M., revealed the patient's family was called to the bedside to discuss the patient's condition and agreed to not resuscitate and provide comfort care. There was no documentation in the medical record stating when the patient was extubated and taken off the ventilator. 24. Review of the medical record for Patient #17 revealed the patient presented to the facility on 11/10/18 due to cardiac arrest. The patient was intubated with increasing seizure activity. Nursing progress notes stated Patient #17 was extubated on 11/13/18 at 4:42 P.M. On 11/13/18, Fentanyl 1000 mcg was dispensed from the AMDS at 10:39 P.M. and Versed 10 mg was dispensed at 10:40 P.M., both via override, prior to the physician order. On 11/13/18 at 10:57 P.M., Physician A ordered Fentanyl 1,000 mcg IV push and at 10:58 P.M., ordered Versed 10 mg IV push. The medication administration record documented the Fentanyl was administered at 10:57 P.M. and the Versed was administered at 10:58 P.M. Patient #17 was pronounced dead at 11:20 P.M. by Physician A. 25. Review of the medical record for Patient #18 revealed the patient presented to the facility on 05/24/18 due to septic shock. On 05/28/18, the patient was transferred to ICU, intubated and placed on a ventilator. On 05/28/18 at 10:59 P.M., Fentanyl 1,000 mcg and Versed six mg were dispensed from the AMDS via override, prior to the physician order. On 05/28/18 at 11:20	A 491		

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A 491	Continued From page 13 P.M., the physician ordered Fentanyl 1,000 mcg and Versed six mg IV push. The medication administration record revealed the Fentanyl 1,000 mcg and the Versed 6 mg were administered on 05/28/18 at 11:20 P.M. Patient #18 was pronounced dead by Physician A at 11:40 P.M. There was no documentation in the medical record stating when the patient was extubated and taken off the ventilator. 26. Review of the medical record for Patient #19 revealed the patient presented to the facility on 04/02/17 at 2:54 A.M. due to cardiac arrest. Patient #19 was intubated before arriving in the ICU. Fentanyl 2,000 mcg was dispensed from the AMDS via override; 20 vials were removed at 10:44 P.M., five vials removed at 11:02 PM, three vials were removed at 11:03 P.M. and four vials were removed at 11:05 P.M. Versed 2 mg was dispensed from the AMDS via override; five vials at 10:45 P.M. and five more vials at 11:02 P.M. Dilaudid 10 mg dosages were dispensed from the AMDS via override, one at 10:45 P.M. and one at 11:02 P.M. Review of the physician orders revealed two orders for Fentanyl 1,000 mcg IV push, one at 10:53 P.M. and one at 11:15 P.M.; Dilaudid 10 mg IV push were ordered, one at 10:53 P.M. and one at 11:15 P.M.; and two orders for Versed 10 mg IV push, one at 10:53 P.M. and 11:15 P.M. The medication administration record documented Fentanyl was administered at 10:57 P.M. and 11:16 P.M.; Dilaudid was administered at 10:57 P.M. and 11:16 P.M.; and Versed 10 mg IV push was administered at 10:57 P.M. and 11:16 P.M. Patient #19 was pronounced dead by Physician A at 11:30 P.M. There was no documentation in the medical record stating when the patient was extubated and taken off the ventilator.	A 491		

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A 491	Continued From page 14 27. Review of the medical record for Patient #20 revealed the patient presented to the facility on 10/22/18 due to altered mental status related to drug abuse. Patient #20 was intubated before arriving in the ICU. Review of Physician A's progress note revealed overnight Patient #20 remained on maximal doses of medication to sustain blood pressure. The family was updated at the bedside and decided to withdraw treatment. Fentanyl 800 mcg was dispensed from the AMDS at 2:34 A.M. and 200 mcg was dispensed at 2:35 A.M. override; Versed 10 mg was dispensed at 2:33 A.M. and 2:52 A.M. via override; and Dilaudid 10 mg was dispensed at 2:54 A.M. via override, prior to the physician order. Review of the physician orders revealed Fentanyl 1,000 mcg IV push was ordered on 10/24/18 at 3:00 A.M., Dilaudid 10 mg IV push was ordered at 3:05 A.M. and two doses of Versed 10 mg IV push was ordered at 3:00 A.M. and 3:23 A.M. The medication administration record revealed Fentanyl and one dose of Versed were administered at 3:00 A.M.; Dilaudid at 3:05 A.M.; and the second dose of Versed was administered at 3:05 A.M. Patient #20 was pronounced dead at 3:13 A.M. There was no documentation in the medical record stating when the patient was extubated and taken off the ventilator. 28. Review of the medical record for Patient #21 revealed the patient presented to the facility on 09/30/18 at 9:04 P.M. due to a collapsed lung. The patient was intubated and chest tubes were placed in the emergency room. On 09/30/18 at 11:10 P.M., the physician ordered Fentanyl 600 mcg IV push and Versed six mg IV push. Both these dosages of medications were dispensed	A 491		

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A 491	Continued From page 15	A 491		

from the AMDS with override at 11:12 P.M. The medication administration record documented both medications were administered at 11:22 P.M.. The patient was extubated and taken off the ventilator at at 11:30 P.M. Patient #21 was pronounced dead at 11:53 A.M.

29. Review of the medical record for Patient #22 revealed the patient presented to the facility on 09/17/18 due to abdominal pain and fevers. The patient suffered a cardiac arrest on 09/25/18, was intubated and put on a ventilator. Review of the physician orders revealed Fentanyl 500 mcg IV push and Versed six mg IV push was ordered on 09/25/18 at 8:00 P.M. Both dosages of these medications were dispensed by the AMDS system via override at 8:02 P.M. The medication administration record documented both medications were administered at 8:25 P.M. Patient #22 was pronounced dead at 9:25 P.M. by Physician A. There was no documentation in the medical record stating when the patient was extubated and taken off the ventilator.

30. Review of the medical record for Patient #23 revealed the patient presented to the facility on 07/15/18 time due to cardiac arrest. The patient was intubated before arriving in the ICU. Review of the physician orders revealed Fentanyl 1,000 mcg IV push was ordered on 07/15/18 at 1:25 A.M. Fentanyl was dispensed from the AMDS system via override at 1:17 A.M. The medication administration record revealed the medication was administered at 1:25 A.M. Patient #23 was pronounced dead at 1:28 A.M. by Physician A. There was no documentation in the medical record stating when the patient was extubated and taken off the ventilator.

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A 491	Continued From page 16 31. Review of the medical record for Patient #24 revealed the patient presented to the facility on 04/01/18 at 8:20 P.M. due to cardiopulmonary arrest. The patient was intubated before arriving in the ICU. The Versed was dispensed from the AMDS system at 9:29 P.M. and the Fentanyl was dispensed at 9:30 P.M. both via override, prior to the physician order. Review of the physician orders revealed Fentanyl 800 mcg IV push was ordered on 04/01/18 at 9:35 P.M. and Versed six mg IV push was ordered at 9:36 P.M. The medication administration record revealed Fentanyl was administered at 9:35 P.M. and Versed was administered at 9:36 P.M. Patient #24 was pronounced dead at 9:41 P.M. by Physician A. There was no documentation in the medical record stating when the patient was extubated and taken off the ventilator. 32. Review of the medical record for Patient #25 revealed the patient presented to the facility on 03/23/18 due to cardiac arrest. Patient #25 was intubated before arriving at the facility. On 03/25/18, the physician ordered Fentanyl 500 mcg IV push at 9:20 P.M. and Versed six mg IV push at 9:21 P.M. Versed was dispensed from the AMDS at 9:23 P.M. and Fentanyl was dispensed at 9::25 P.M. via override and after pharmacy review. The medication administration record documented the Versed was administered at 9:29 P.M. and the Fentanyl was administered at 9:30 P.M. Patient #25 was extubated and pronounced dead at 9:45 P.M. by Physician A. 33. Review of the medical record for Patient #26 revealed the patient presented to the facility on 01/11/18 due to increased liver enzymes. On 01/14/18 at 7:00 A.M., the patient arrested and was intubated. On 01/14/18 at 9:30 P.M., the	A 491		

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A 491	Continued From page 17 physician ordered Versed six mg IV push and at 9:31 P.M., Fentanyl 1,000 mcg was ordered IV push. Fentanyl was dispensed from the AMDS at 9:33 P.M. and the Versed was dispensed at 9:34 P.M., both via override. The medication administration record revealed the medications were administered at 9:51 P.M. Patient #26 was pronounced dead at 10:05 P.M. by Physician A. There was no documentation in the medical record stating when the patient was extubated and taken off the ventilator. 34. Review of the medical record for Patient #27 revealed the patient presented to the facility on 01/13/18 at 5:52 P. M due to a brain bleed. Patient #27 was intubated in the emergency room before being transferred to ICU. Fentanyl was dispensed from the AMDS on 01/13/18 at 11:47 P.M. with override. The physician ordered Fentanyl 1,000 mcg IV push on 01/14/18 at 12:02 A.M. The medication administration record documented the medication was administered on 01/14/18 at 12:02 A.M. Patient #27 was extubated at 12:03 A.M. Physician A pronounced Patient #27 dead at 12:19 AM. During interview on 01/18/19 between 10:00 A.M. and 2:00 P.M., all findings were confirmed by Nurse G, H, and M.	A 491		

Mount Carmel West –CCN 360035
Plan of Correction

Tag 0000- Initial Comments

Initial Comments	Responsible Person	Completion Date
Preparation and execution of this plan of correction does not constitute an admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies. This plan of correction is prepared and executed solely because it is required by federal/state law. The following constitutes Mount Carmel West's credible allegation of compliance.	President and Chief Operating Officer Mount Carmel Health System, CMS Authorized Individual	2/4/19

Tag 0489- Pharmaceutical Services Condition

Corrective Action	Responsible Person	Completion Date
Finding 1- Proper control and use of central nervous system (CNS) medications		
Refer to Tag 0491		2/4/19

Tag 0491- Pharmacy Administration

Corrective Action	Responsible Person	Completion Date
Finding 1- Accessing CNS medications from the automated medication dispensing system (AMDS) by override		
Removed ability to override opioids from inpatient care units throughout the hospital, including limited availability of override of Fentanyl in the AMDS except for a single vial of Fentanyl 250 mcg injection in ICU for emergency procedures only and a single morphine injection of 5mg/10mL (0.5mg/mL) preservative-free vial for emergency procedures in the NICU only.	Chief Pharmacy Officer	1/28/19
Evaluated all medications available in the AMDS and reduced the number of all medications available for override by approximately 55%.	Chief Pharmacy Officer	1/28/19
Revised policy, "Automated dispensing system: Medication Override Policy" (Attachment A) defining limitation of over-ride functions to categories of emergency life sustaining treatment, emergent supportive care, antidotes, rescue and reversal agents including definitions for each category. Approved by Pharmacy Policy and Procedure Committee, then by the Mount Carmel Health System Pharmacy and Therapeutics (P&T) Committee. The Health System P&T Committee is authorized by the Health system Medical Executive Committee to approve the pharmacy policies. Final approval for implementation was by the System Chief Pharmacy Officer.	Chief Pharmacy Officer	2/2/19 – Approval via Committee structure

Corrective Action	Responsible Person	Completion Date
Implemented a hard stop in units that have profiled AMDS (nurses are not provided the option to remove), prohibiting access by registered nurses to all AMDS override medications except for approved drugs for management of three emergency scenarios (life threatening, supportive emergent care, antidotes/reversal/rescue agents) as defined in policy, "Automated dispensing system: Medication Override".	Chief Pharmacy Officer	1/28/19
Education: Developed and distributed communication to all registered nurses providing direct patient care in the acute hospital environment, all physicians on the medical staff (active, courtesy/consulting/house officer, i.e., providers with inpatient clinical privileges), medical residents and pharmacists on new reduction of central nervous system high risk medications available in the AMDS and limitations for override of medications and expectations for compliance. Communicated via daily safety huddles and tiered accountability structure (A daily management system designed so problems can be quickly identified. Front-line staff are empowered to fix the problems that they can, and problems that the front-line staff cannot fix are escalated and countermeasures created quickly. Daily tiered meetings are an integral element of a daily management system. The objective of the tiered meetings is to have an alignment across the organization to achieve a common goal.) Nursing and pharmacy staff on leave or off the current schedule, prior to return to work, will be required to review and attest to the education.	Chief Pharmacy Officer Chief Nursing Officer	1/28/19 - pharmacy staff completed 1/28/19 – nursing staff education implemented and ongoing

Corrective Action	Responsible Person	Completion Date
Education: Communicated requirements and expectations of the updated PVW policy to a subset of critical care physicians via electronic notification.	Vice President of Medical Affairs	12/11/18
All medical staff were provided with communication about AMDS emergency override changes including a list of the AMDS emergency override medications via electronic notification	Chief Clinical Officer	2/1/19
All medical staff were provided with communication about high risk CNS intravenous drug guidelines discussing restrictions for maximum single and cumulative doses of high risk CNS medications via electronic notification	Chief Clinical Officer	2/4/19
For medical staff members with inpatient clinical privileges, an electronic notification with read receipt verification requested will be sent by the Chief Clinical Officer outlining changes to the PVW policy, AMDS override restrictions, and restrictions for maximum single and cumulative doses of high risk CNS medications. A second notification will be disseminated by the Chief Clinical Officer/Vice President of Medical Affairs if the hospital determines the first request has not been opened as received by the email recipients.		2/7/19 notification sent with read receipt requested

Corrective Action	Responsible Person	Completion Date
Monitoring Plan: Implemented daily pharmacist monitoring of post-administration medication orders of high risk CNS medications removed from AMDS via emergency override for validation of compliance with revised policy "Automated dispensing system: Medication Override policy". 100% of high risk CNS emergency overrides are reviewed daily, with non-compliance routed through nursing or provider chains of command for correction. Numerator: # of overrides of high risk CNS medications reviewed and escalated if not appropriate per policy Denominator: # of overrides of high risk CNS medications reviewed Goal: 100% Data will be reviewed at the Monthly Quality Safety Council, then sent to the Quality Board and Board of Directors every other month. Monitoring will continue until the Quality Safety Council determines sustained compliance has been achieved. Generally this is a 3 month period of compliance at the established goal/target; however, the Quality Safety Council has the discretion to determine sustained compliance. At the time of this determination, the committee will determine further periodic monitoring as appropriate (e.g., random audits, spot checks).	Chief Pharmacy Officer	12/17/18 ongoing
Finding 2- Adherence to the High Risk CNS Medication Guideline		
The hospital removed the physician from the schedule, and then removed physician A's ability to provide patient care. Additionally, the medical group terminated physician A's employment. The hospital also placed 20 staff on administrative leave pending further investigation.	President of the Medical Group and Chief Human Resources Officer	Removal of physician from schedule 11/21/18 Physician employment contract term date: 12/5/18 Staff suspension date(s): 12/12/18 to 1/28/19

Corrective Action	Responsible Person	Completion Date
Developed and implemented a policy, "Pharmacist Documentation and Escalation" (Attachment B) defining documentation and escalation requirements for any concerns related to medication ordering or administration (including dosage of CNS medications). Approved by Pharmacy Policy and Procedure Committee. Final approval for implementation was by the System Chief Pharmacy Officer.	Chief Pharmacy Officer	12/17/18
Reviewed and updated the hospital's "Chain of Command" policy which outlines escalation steps for care providers when perceived variances in care identified. The policy was revised to include pharmacists' actions for chain of command escalation. Reviewed by Chief Pharmacy Officer and Director of Clinical Practice. Approved by the Chief Nursing Officer. There were no changes to chain of command for nurses, however all registered nurses providing direct patient care will be refreshed on the chain of command policy via individual shift unit huddles, unit meetings and one-on-one discussions with sign-in sheet validation.	Chief Nursing Officer Chief Pharmacy Officer	12/17/18 and ongoing 2/6/19 ongoing
Education: Provided education to pharmacists on requirements and expectations for compliance as specified in Policies: "Pharmacist Documentation and Escalation" with signed understanding of performance expectations attestations.	Chief Pharmacy Officer	1/4/19
Chain of command issues are entered into the facility's event management system and are reviewed daily by leadership.	Chief Pharmacy Officer	1/24/19

Corrective Action	Responsible Person	Completion Date
Monitoring Plan: Implemented on-going monitoring of pharmacists' compliance with "Pharmacist Documentation and Escalation" policy for target high risk CNS medications outside the acceptable range with sign-off by pharmacy leader. Numerator: daily review of # of high risk CNS medication orders with appropriate dosing with signoff by pharmacy leader Denominator: daily review of # of high risk CNS medications orders outside acceptable range Goal: 100% compliance Numerator: daily review of # of high risk CNS medication orders documented per policy Denominator: daily review of # of high risk CNS medication orders with required documentation Goal: 100% compliance Data will be reviewed at the Monthly Quality Safety Council, then sent to the Quality Board and Board of Directors every other month. Monitoring will continue until the Quality Safety Council determines sustained compliance has been achieved. Generally this is a 3 month period of compliance at the established goal/target; however, the Quality Safety Council has the discretion to determine sustained compliance. At the time of this determination, the committee will determine further periodic monitoring as appropriate (e.g., random audits, spot checks).	Chief Pharmacy Officer	12/17/18 Ongoing
Educated pharmacists and medical staff on implementation of process for maximum single and cumulative doses for high risk CNS medications for pharmacist rejection of medication orders that exceed established dosing with signed attestations by pharmacy staff. Evidence of communication with medical staff via email memorandum.	Chief Pharmacy Officer, Chief Clinical Officer, Vice President of Medical Affairs	Pharmacists completed 2/4/19 Medical Staff implemented 2/4/19

Corrective Action	Responsible Person	Completion Date
Finding 3- Adherence to Palliative Ventilator Withdrawal (PVW) policy		
Revised policy, " Palliative Ventilator" (Attachment C) which specifies palliative ventilator withdrawal is for comfort measures only, with stipulations mandating use of the Terminal Ventilator Withdrawal (TVW) order set that includes limited medications and dosage parameters, prohibits use of verbal orders for implementation of TVW order set, and includes requirement for physician to receive permission from a Medical Director or a Vice President of Medical Affairs who are available at any time (24/7) for use of medications outside of dosing range of the medications included in the TVW order set. Reviewed by the VP of Medical Affairs, Chief Pharmacy Officer, and the Medical Director of Palliative Care. Approved for implementation by the Chief Nursing Officer.	Vice President of Medical Affairs and Chief Nursing Officer	12/11/18
Developed a PowerPoint presentation, "High Reliability Organization," (Attachment E) as an education vehicle covering ZeroHarm/Culture of Safety expectations (included chain of command and escalation of concerns), "Palliative Ventilator" policy requirements, mandated use of TVW order set, appropriate medication dosages, verbal order limitations, required pharmacy review of orders, and registered nurse documentation requirements on the Significant Event Form in the medical record related to ventilator withdrawal for dissemination to clinical care providers.	President, Vice President of Medical Affairs, Chief Nursing Officer and Chief Pharmacy Officer	12/10/18
Education: Provided focused education to critical care physicians, ICU registered nurses, advanced practice nurses, and pharmacists via "High Reliability Organization" PowerPoint presentations conducted by hospital leadership, with signed attestations of understanding of requirements and expectations for compliance by these providers.	President and Chief Operating Officer, Vice President of Medical Affairs, Chief Nursing Officer and Chief Pharmacy Officer	12/14/18
Developed and distributed communication to all registered nurses providing direct patient care in the acute hospital environment regarding the PVW Policy and order set. Communicated via daily safety huddles and tiered accountability. Nursing staff on leave or off the current schedule, prior to return to work, will receive and attest to the education.	Chief Nursing Officer	2/5/19 ongoing

Corrective Action	Responsible Person	Completion Date
Education: Communicated requirements and expectations of the updated PVW policy to a subset of critical care physicians via electronic notification. All medical staff were provided with communication about AMDS emergency override changes including a list of the AMDS emergency override medications via electronic notification All medical staff were provided with communication about high risk CNS intravenous drug guidelines discussing restrictions for maximum single and cumulative doses of high risk CNS medications via electronic notification For medical staff members with inpatient clinical privileges, an electronic notification with read receipt verification requested will be sent by the Chief Clinical Officer outlining changes to the PVW policy, AMDS override restrictions, and restrictions for maximum single and cumulative doses of high risk CNS medications. A second notification will be disseminated by the Chief Clinical Officer/Vice President of Medical Affairs if the hospital determines the first request has not been opened as received by the email recipients.	Vice President of Medical Affairs Chief Clinical Officer Chief Clinical Officer	12/11/18 2/1/19 2/4/19 2/7/19 notification sent with read receipt requested
Education: Educated internal medicine and surgical residents on use of TVW order set with signed attestations acknowledging receipt and expectations for compliance. An electronic notification will also be sent to all residents with required read receipt requested by the Chief Clinical Officer. The resident's program director will follow-up with the resident if no receipt response is received. New resident orientation will include this education. Residents rotating into a program will be educated by the program director prior to starting the rotation.	Vice President of Medical Affairs, GME Program Directors, and Chief Nursing Officer Regional Director of Graduate Medical Education	12/17/18 2/7/19 notification sent with read receipt requested Added to resident orientation checklist 2/8/19
As an additional fail safe, all TVW order sets will be reviewed by the charge nurse prior to implementation to identify any instances of noncompliance, with escalation to hospital leadership for intervention as necessary.	Chief Nursing Officer	2/4/19

Corrective Action	Responsible Person	Completion Date
Monitoring Plan: Initiated daily monitoring of compliance to use of the Palliative Ventilator Withdrawal Order Set for all patients being palliatively weaned from a ventilator with requirement for immediate escalation to hospital leadership for any instance of non-compliance. All instances where approval was given by the Medical Director or Vice President of Medical Affairs to prescribe outside the limits of the order set, now require notification to the Mount Carmel Health System Chief Clinical Officer or designee, for review within 48 hours for appropriateness of dosage approval. Additionally, instances of approval will be forwarded to peer review process for physician profiling, tracking and trending. Numerator: # palliative ventilator withdrawals compliant with the power plan Denominator: # palliative ventilator withdrawals Goal: 100% compliance Data will be reviewed at the Monthly Quality Safety Council, then sent to the Quality Board and Board of Directors every other month. Monitoring will continue until the Quality Safety Council determines sustained compliance has been achieved. Generally this is a 3 month period of compliance at the established goal/target; however, the Quality Safety Council has the discretion to determine sustained compliance. At the time of this determination, the committee will determine further periodic monitoring as appropriate (e.g., random audits, spot checks).	Vice President of Medical Affairs and Chief Nursing Officer	12/24/18 Ongoing

Corrective Action	Responsible Person	Completion Date
Monitoring Plan: Initiated on-going monthly monitoring for validating compliance of registered nurse documentation on Significant Event Form of Palliative Ventilator Withdrawal. Numerator: # of complete nursing documentation (all elements) on event form for palliative ventilator withdrawal instances Denominator: # of palliative ventilator withdrawal instances Goal: 100% compliance Data will be reviewed at the Monthly Quality Safety Council, then sent to the Quality Board and Board of Directors every other month. Monitoring will continue until the Quality Safety Council determines sustained compliance has been achieved. Generally this is a 3 month period of compliance at the established goal/target; however, the Quality Safety Council has the discretion to determine sustained compliance. At the time of this determination, the committee will determine further periodic monitoring as appropriate (e.g., random audits, spot checks).	Vice President of Medical Affairs and Chief Nursing Officer	12/24/18 Ongoing
Finding 4- Proper use of verbal/telephone orders		
Reviewed and updated policy, "Medication Order" (Attachment D) for clarity of requirements for verbal and telephone order expectations. Reviewed by Pharmacy Policy and Procedure Committee, Administrative Policy Committee, and Chief Pharmacy Officer. Approved for implementation by Mount Carmel Leadership Accreditation Council.	Chief Pharmacy Officer	1/16/19
Revised " Palliative Ventilator" policy which specifies palliative ventilator withdrawal is for comfort measures only, with stipulations mandating use of the TVW order set that includes limited medications and dosage parameters, prohibits use of verbal orders for implementation of TVW order set, and includes requirement for physician to receive permission from Medical Director or Vice President of Medical Affairs for use of medications outside of medications included in the TVW order set. Reviewed by the VP of Medical Affairs, Chief Pharmacy Officer, and the Medical Director of Palliative Care. Approved for implementation by the Chief Nursing Officer.	Vice President of Medical Affairs and Chief Nursing Officer	12/11/18 by CNO

Corrective Action	Responsible Person	Completion Date
Developed a PowerPoint presentation, "High Reliability Organization," as an education vehicle covering ZeroHarm/Culture of Safety expectations, "Palliative Ventilator" policy requirements, mandated use of TVW order set, appropriate medication dosages, verbal order limitations, required pharmacy review of orders, and registered nurse documentation requirements on the Significant Event Form in the medical record related to ventilator withdrawal for dissemination to clinical providers	Vice President of Medical Affairs and Chief Nursing Officer	12/10/18
Education: Educated critical care physicians, ICU registered nurses, advanced practice nurses, and pharmacists via "High Reliability Organization" PowerPoint presentations conducted by hospital leadership, with signed attestations of understanding of requirements and expectations for compliance.	Vice President of Medical Affairs and Chief Nursing Officer	12/14/18
Education: Developed and distributed communication to all registered nurses providing direct patient care in the acute hospital environment regarding the PVW Policy and required use of order set. Communicated via daily safety huddles and tiered accountability. Nursing staff on leave or off the current schedule, prior to return to work, will receive and attest to the education.	Chief Nursing Officer	2/6/19 ongoing
Education: Developed and distributed communication to all registered nursing providing direct patient care in the acute hospital environment regarding limitations on use of verbal and telephone orders. Communicated via daily safety huddles and tiered accountability. Nursing staff on leave or off the current schedule, prior to return to work, will receive and attest to the education.	Chief Nursing Officer	Implemented 2/8/19 ongoing

Corrective Action	Responsible Person	Completion Date
Education: Communicated requirements and expectations of the updated PVW policy to a subset of critical care physicians via electronic notification.	Vice President of Medical Affairs	12/11/18
All medical staff were provided with communication about AMDS emergency override changes including a list of the AMDS emergency override medications via electronic notification	Chief Clinical Officer	2/1/19
All medical staff were provided with communication about high risk CNS intravenous drug guidelines discussing restrictions for maximum single and cumulative doses of high risk CNS medications via electronic notification	Chief Clinical Officer	2/4/19
For medical staff members with inpatient clinical privileges, an electronic notification with read receipt verification requested will be sent by the Chief Clinical Officer outlining changes to the PVW policy, AMDS override restrictions, and restrictions for maximum single and cumulative doses of high risk CNS medications. A second notification will be disseminated by the Chief Clinical Officer/Vice President of Medical Affairs if the hospital determines the first request has not been opened as received by the email recipients.	Chief Clinical Officer Vice President of Medical Affairs	2/7/19 notification sent with read receipt requested
Monitoring Plan: Pharmacy department is collecting medication order data. Numerator: total verbal and telephone medication orders Denominator: total medication orders Goal: ≤10% verbal and telephone orders for medications Data is reviewed by the Mount Carmel Health System Medication Safety Task Force twice per month. Data will be reviewed at the Monthly Quality Safety Council, then sent to the Quality Board and Board of Directors every other month. Monitoring will continue until the Quality Safety Council determines sustained compliance has been achieved. Generally this is a 3 month period of compliance at the established goal/target; however, the Quality Safety Council has the discretion to determine sustained compliance. At the time of this determination, the committee will determine further periodic monitoring as appropriate (e.g., random audits, spot checks).	Chief Pharmacy Officer	1/14/19 ongoing

Corrective Action	Responsible Person	Completion Date
Finding 5- Pharmacy approving large doses of opioids		
Developed and implemented a "Pharmacist Documentation and Escalation Policy" defining documentation and escalation requirements for any concerns related to medication ordering or administration (including dosage of CNS medications)	Chief Pharmacy Officer	12/17/18
Education: Provided education to MCHS pharmacists on requirements and expectations for compliance as specified in Policies: "Pharmacist Documentation and Escalation" and "Chain of Command" with signed understanding of performance expectations attestations.	Chief Pharmacy Officer	1/4/19
Chain of command issues are entered into the facility's event management system and are reviewed daily by leadership.	Chief Pharmacy Officer	1/24/19
Monitoring Plan: implemented on-going monitoring of pharmacists' compliance with "Pharmacist Documentation and Escalation" policy for target high risk CNS medications outside the acceptable range with sign-off by pharmacy leader. Numerator: daily review of # of high risk CNS medication orders with appropriate dosing with signoff by pharmacy leader Denominator: daily review of # of high risk CNS medication orders Goal: 100% compliance Numerator: daily review of # of high risk CNS medication orders documented per policy Denominator: daily review of # of high risk CNS medication orders with required documentation Goal: 100% compliance Data will be reviewed at the Monthly Quality Safety Council, then sent to the Quality Board and Board of Directors every other month. Monitoring will continue until the Quality Safety Council determines sustained compliance has been achieved. Generally this is a 3 month period of compliance at the established goal/target; however, the Quality Safety Council has the discretion to determine sustained compliance. At the time of this determination, the committee will determine further periodic monitoring as appropriate (e.g., random audits, spot checks).	Chief Pharmacy Officer	12/17/18 Ongoing

Corrective Action	Responsible Person	Completion Date
Educated pharmacists on implementation of process for maximum single and cumulative doses for high risk CNS medications for pharmacist rejection of medication orders that exceed established dosing with signed understanding of performance expectations attestations by pharmacy staff.	Chief Pharmacy Officer	2/4/19

Attachment A

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: Automated Dispensing System- Medication Overrides

DEPARTMENT OVERSIGHT AND MAINTENANCE: Pharmacy

PURPOSE:
To define the appropriate use of the override function, and identify the best practices to keep patients safe.

POLICY:
The use of the override function in the automated dispensing machine is minimized by limiting this type of access to emergency situations. Emergent situations include 3 general categories: life sustaining, emergent supportive care, and antidotes/rescue/reversal agents.

RESPONSIBLE PERSONS: Pharmacists, Registered Nurses (RN), Licensed Independent Practitioners (LIP) (Physicians, Advanced Practice Registered Nurse Practitioners), Physician Assistant's (PA)

SPECIAL COMMENTS:
Override medications are medications that can be accessed by nursing staff before review of an order by the pharmacist. The purpose of the override function is to allow for quick administration of medications in emergency situations to prevent patient harm. However, best practice includes prospective pharmacist review of all medication orders prior to administration of the drug. The override function can only be used in emergency situations when time does not permit the pharmacist review, such as circumstances when patient harm could result from delay in administration of a medication, including situations in which the patient experiences a sudden clinical decline.

The override function is specific to profiled Pyxis machines (inpatient units). The override function will not be utilized in patient care areas where non-profiled Pyxis machines are used, such as the Emergency Department, Cath Lab, Endoscopy, OR, and other procedural areas.

Automated Dispensing System downtime and critical override is reviewed in the "Automated Dispensing System – Downtime Procedures For Pyxis ES"

There will be instances where Pyxis removals using the override function will be necessary to facilitate normal process of care (i.e. drug shortages, kits, etc). These will not be included in the override addendum as they are often transient due to unexpected drug shortage replacements.

PROCEDURE:
1. In most areas, automated dispensing systems (Pyxis) are interfaced with the pharmacy system so that all new orders entered are viewable under each patient in the Pyxis medication profile.
2. Override medications are customized based on the level of care provided on a specific patient care unit/area.
    a. Additional safety features will be utilized for medications that are identified as having a higher risk for harm (i.e. pop-up alerts in Pyxis, nurse witness, restrictions to certain patient populations).

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SUBJECT: Automated Dispensing System- Medication Overrides

3. Any changes made to the override medications (Refer to Addendum) will be reviewed by the Pharmacy and Therapeutics Committee for approval. Adjustments to the override medications, related to drug supply challenges, will require Pharmacy and Therapeutics approval if a permanent change in drug supply option occurs.
4. The override function will only be utilized to access medications in emergency situations to prevent patient harm. Prior to administration of a medication that has been removed by the override function the following must be reviewed for appropriateness prior to administration:
    a. Verification that the medication selected for administration is correct based on the order and product label.
    b. Drug, dose, frequency, and route of administration are verified.
    c. Verification that the medication is stable based on visual examination for particulates or discoloration and the medication is not expired.
    d. Contraindications to consider prior to administration:
        - Real or potential allergies or sensitivities
        - Therapeutic duplication
        - Real or potential interactions between the prescription and other medications, food, and laboratory values
        - Variation in dosing or administration from organizational criteria for use, such as IV Guidelines
5. Prompt documentation of order and administration must occur.
6. Pyxis override monitoring is an important safety task for the Responsible Pharmacist and, in their absence, assigned to their pharmacy leader team:
    a. Annually: The override medication lists in Addendum will be reviewed for appropriateness.
    b. Weekly: A review of Pyxis override trends will be conducted and communicated to hospital leadership.
    c. Daily (Except weekends and holidays): Targeted review of high risk CNS medication Pyxis overrides as well as high risk CNS medication multi-dose Pyxis override removals will be reviewed daily (or day following weekends and holidays) and reported to hospital leadership. Any inappropriateness will be noted, evaluated, and escalated to the appropriate department leader for review and resolution.

DEFINITIONS:

Automated dispensing cabinets (ADCs) – Computerized drug storage devices or cabinets that allow medications to be stored and dispensed near the point of care while controlling and tracking drug distribution. They also are called unit based cabinets (UBCs), automated dispensing devices (ADDs), automated distribution cabinets or automated dispensing machines (ADMs). Mount Carmel currently uses Pyxis for automated dispensing cabinets.

Override - The process of bypassing the pharmacist's review of a medication order to obtain a medication from the Pyxis, when assessment of the patient indicates that a delay in therapy (to allow for a pharmacist's review of the order) would harm the patient.

Profiled Pyxis - An ADC/Pyxis that allows a practitioner to select a drug from a patient-specific list on the ADC screen and obtain a medication only after the order has been verified by a pharmacist.

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SUBJECT: Automated Dispensing System- Medication Overrides

Emergency Situations		
Life Sustaining	**Emergent supportive care**	**Antidotes, rescue, and reversal agents**
Blood pressure control in medical emergencies (AMI, ACS, stroke, sepsis, intubation, etc.)	Acute psychotic disorder; Severe Agitation	Anaphylaxis; respiratory emergencies; allergic reactions
Blood pressure control for emergent hypertensive pregnant patient	Chest Pain	Bupivacaine or ropivacaine toxicity
Emergent intubation	Emergent procedure	Magnesium sulfate toxicity
Lung surfactant (RDS)	Fluid bolus, Blood administration, patency of an IV, required concurrent compatible infusion	Emergency reversal of rocuronium (unable to intubate patient following paralytic administration)
Management of acute/emergent acidosis	Plasma volume expansion for open heart post-op patient	Reversal of opiates
Post-partum hemorrhage; Severe Uterine Bleeding	Seizures	
Preeclampsia		
Prevention of labor		
Symptomatic cardiac arrhythmias (i.e. bradycardia, PSVT, Rapid Ventricular Response)		
Symptomatic critical hypoglycemia		

EXPECTED OUTCOME:
Safe and accurate medication management and administration.

REFERENCE:
Institute for Safe Medication Practices (ISMP) Guidance on the Interdisciplinary Safe Use of Automated Dispensing Cabinets

ASHP Practice Resource for Automated Dispensing Cabinet Overrides

Joint Commission Standards MM.2.30; MM.4.10; MM.5.10; MM.05.01.01; MM.08.01.01

KEY WORDS: Medication overrides, automated dispensing

Developed By: Pharmacy Policy & Procedure committee

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: Automated Dispensing System- Medication Overrides

DEVELOPED BY: Pharmacy Policy & Procedure Team

ORIGINAL ISSUE DATE: MCW, 9/08; MCE, 9/08; MCSA, 9/08; MCNA 8/10

REVIEW/REVISION DATE: 10/08(addendum), 1/09, 3/09 (addendum), 7/09 (addendum), 3/10 (addendum), 8/10 Policy and addendum; 5/14, 9/15, 8/17, 1/18, 1/19, 2/19

REPLACES: Medication Overrides

REVIEWED BY: Pharmacy Policy and Procedure Team

APPROVAL FOR IMPLEMENTATION BY: *Janet Whitley (Chief Pharmacy Officer)*

DATE: 2/2/19

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: Automated Dispensing System- Medication Overrides

ADDENDUM

EMERGENCY CATEGORY	EMERGENT SITUATIONS FOR INPATIENT PYXIS	DRUG	PATIENT POPULATION Med/Surg = 1, ICU = 2, Mother/Infant/ L&D = 3
Antidotes, rescue, and reversal agents	Anaphylaxis; respiratory emergencies; allergic reactions	DiphenhydrAMINE 50 mg/1 mL inj	1, 2, 3
Antidotes, rescue, and reversal agents	Bupivacaine or ropivacaine toxicity	Fat Emulsion 20% infusion, 250mL	1, 2, 3
Antidotes, rescue, and reversal agents	Magnesium sulfate toxicity	Calcium gluconate 1000 mg/10 mL inj*	3
Antidotes, rescue, and reversal agents	Reversal of rocuronium only - if unable to intubate a patient following paralytic administration	Sugammadex 500mg/5 mL inj (4 vials)*	2
Antidotes, rescue, and reversal agents	Reversal of opiates	Naloxone 0.4mg/1 mL inj	1, 2, 3
Emergent supportive care	Acute psychotic disorder	OLANZapine 10 mg inj, powder vial*	1, 2
Emergent supportive care	Severe agitation	**LORazepam Seizure/Agitation Kit** LORazepam 2 mg/1 ml inj x 2 vials*	1, 2, 3
Emergent supportive care	Chest pain	Nitroglycerin 0.4 mg SL tabs (#25), Nitroglycerin 50 mg/250 mL infusion	1, 2
Emergent supportive care	Fluid bolus, Blood administration, patency of an IV, required concurrent compatible infusion	IV solutions (plain)	1, 2, 3
Emergent supportive care	Plasma volume expansion for open heart post-op patient	Albumin 5%, 12.5 Gm/250 mL infusion	2
Emergent supportive care	Emergent procedure	Morphine 5 mg/10 mL vial (PF) x 1*	Neonatal ICU only
Emergent supportive care	Emergent procedure	FentaNYL 250 mcg/5 mL inj x 1*	2
Emergent supportive care	Seizures	**LORazepam Seizure/Agitation Kit** LORazepam 2 mg/ml inj x 2 *	1, 2, 3
		PHENobarbital 65 mg/1 mL inj x 1*	Neonatal ICU only

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EMERGENCY CATEGORY	EMERGENT SITUATIONS FOR INPATIENT PYXIS	DRUG	PATIENT POPULATION Med/Surg = 1, ICU = 2, Mother/Infant/ L&D = 3
Life Sustaining	Blood pressure control in medical emergencies (AMI, ACS, stroke, sepsis, intubation, etc)	DOPamine 400mg/250 mL infusion EPINEPHrine 1 mg/10 mL syringe NICARdipine 20 mg/200 mL infusion Nitroglycerin 50 mg/250 mL infusion Norepinephrine 4 mg/250 mL infusion Phenylephrine 1000 mcg/10 ml syringe	1, 2, 3
Life Sustaining	Blood pressure control for emergent hypertensive pregnant patient	HydrALAZINE 20 mg/1 mL inj*	3
		Labetalol 20 mg/4 mL syringe*	3
Life Sustaining	Management of acute/emergent acidosis	Sodium bicarbonate 50 mEq/50 mL syringe	1, 2, 3
Life Sustaining	Emergent intubation	**RSI: Rapid Sequence Intubation Kit(ICU & MCNA)** 1 x Propofol 200 mg/20 mL inj 1 x Ketamine 200 mg/20 mL inj 2 x Succinylcholine 200 mg per 10 mL inj 2 x Rocuronium 50 mg/5 mL inj 1 x Etomidate 40 mg/20 mL inj 3 x Midazolam 2 mg/2 mL inj *(Etomidate can be sub to 2 vials of 20mg/10ml with all kits)	2 MCNA
		Intubation Kit (Med/Surg units and L&D) 2 x Etomidate 20 mg/10mL inj 2 x Midazolam 2mg/2mL inj	1,3
Life Sustaining	Symptomatic critical hypoglycemia	Dextrose 50% 25gm/50mL inj syringe	1, 2, 3
Life Sustaining	Lung surfactant (RDS)	Poractant Alfa (Curosurf®) 80mg/mL inj 1.5 mL and 3 mL vials	3

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SUBJECT: Automated Dispensing System- Medication Overrides

EMERGENCY CATEGORY	EMERGENT SITUATIONS FOR INPATIENT PYXIS	DRUG	PATIENT POPULATION Med/Surg = 1, ICU = 2, Mother/Infant/ L&D = 3
Life Sustaining	Post-partum hemorrhage; Severe Uterine Bleeding	OB Emergency Hemorrhage Kit (L&D) 1 x Carboprost 250 mcg/1 mL inj 1 x Methylergonovine 0.2 mg/1 mL, inj 5 x Misoprostol 200 mcg tabs, 3 x Oxytocin 10 units/1 mL inj	3
		Tranexamic Acid 1 Gm/10 ml inj	3
Life Sustaining	Preeclampsia	Magnesium Sulfate 2 Gm/100 mL IVPB* Magnesium Sulfate 4 Gm/100 mL IVPB* Magnesium Sulfate 6 Gm/150 mL IVPB*	3
Life Sustaining	Symptomatic Cardiac arrhythmias (i.e. bradycardia, PSVT, rapid ventricular response)	Adenosine 6 mg/2 mL inj Adenosine 300mcg kit (Neonatal ICU only) Atropine 1 mg/1 mL vial DILTIAZem 25 mg/5 mL (bolus) inj vial*	1, 2, 3
Life Sustaining	Prevention of labor	Terbutaline 1 mg/1 mL inj	3
Other	Other	Sterile water and 0.9% Sodium Chloride for irrigation 500mL and 1000mL	1,2,3
Other	Other	Sodium Chloride 0.9%, 10mL inj, flush syringes Sterile water inj, less than 100mL for drug dilution	1,2,3
Other	Other	Unlock refrigerator Unlock non-refrigerated	1,2,3

*additional safety features in place (i.e. pop-up alerts in Pyxis, nurse witness, restrictions to certain patient populations).

Addendum updated: 10/9/2008, 1/22/2009, 3/17/09 (approval P&T, 2/26/09; Med Exec, 3/17/09), 7/23/09, 3/8/10, 10/10, 5/11, 2/14, 5/14, 2/15, 4/15, 4/17, 1/18, 1/19, 2/19

Attachment B

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: PHARMACIST DOCUMENTATION AND ESCALATION PROCESS

DEPARTMENT OVERSIGHT AND MAINTENANCE: Pharmacy

POLICY: Pharmacist Documentation and Escalation Process

Pharmacists have a responsibility to intervene with prescribers for situations where orders need to be clarified. Clinical interventions are defined as actions taken to improve patient outcomes and prevent medication errors or patient harm.

RESPONSIBLE PERSONS: Pharmacists, Pharmacy Leadership Team

SPECIAL COMMENTS:

Pharmacist medication consult documentation is outlined in the pharmacy Drug Therapy Consult Agreement policy

Scope of Practice – Pharmacist are responsible for compliance with the Ohio Board of Pharmacy rules and regulations, the Joint Commission, Ohio Department of Health, DEA, USP, and other federal requirements.

PROCEDURE:

Pharmacist Escalation:

1. For urgent patient safety concerns immediately escalate per the PCS "Chain of Command: Clinical Operation" policy
    a. After escalation, documentation in chart, and VOICE report should be entered for escalated events.
2. Non-urgent escalation should be verbally brought to the attention of pharmacy leadership team with corresponding pharmacy escalation form filled out and handed off (i.e. in person or via email).
    a. Verbal communication is expected, at earliest convenience of the colleague. (i.e. if event occurs over the weekend, verbal communication should occur as soon as the colleague and leadership team are able to touch base).

Pharmacist Documentation:

Clarification of orders in EMR:

1. If a situation is identified that requires prescriber clarification of an existing order, the pharmacist will document the discussion in EMR outlining details of the conversations.
    a. This would include dosing outside of current guidelines that cannot be verified by evidence based literature.
    b. Documentation should ensure full understanding of the problem the pharmacists is attempting to resolve and specific details regarding the clinical intervention.
    c. Documentation should occur before the end of the current shift.
    d. If documentation does not occur before the end of the current shift, every effort should be made to add documentation before patient discharge. If documentation

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SUBJECT: PHARMACIST DOCUMENTATION AND ESCALATION PROCESS

is not added before patient discharge, it should be documented as soon as possible. If documentation is added after current shift, pharmacist should communicate this to pharmacy leadership team as an escalation.

2. After discussion, if there is still a safety concern Pharmacist will communicate with prescriber using the Zero Harm error prevention tools. (example: Pharmacist could use the safety phrase "I have a concern and need to escalate this up the chain of command")
    a. After stating concern, immediately escalate (i.e. verbal or in person) a direct escalation for immediate guidance per the referenced PCS "Chain of Command: Clinical Operation" policy
    b. If escalation was needed, VOICE report will be entered before end of the current shift.
3. If situation required STAT resolution, Refer to PCS "Chain of Command: Clinical Operation" Policy.
    a. Additional verbal or in person updates will be provided to the site and/or regional pharmacy leader if these individuals were not involved in the first escalation step.

Clinical interventions:

1. Pharmacist clinical intervention to prevent patient harm will be documented in the EMR. If a clinical intervention made to prevent patient harm is not accepted, it should be documented and escalated.
2. Restricted medications should have an intervention documented to ensure appropriate utilization.
3. Non-formulary medication use should have an intervention documented.
4. Clinical interventions should be documented before the end of the current shift.
    a. If documentation does not occur before the end of the current shift, every effort should be made to add documentation before patient discharge. If documentation is not added before patient discharge, it should be documented as soon as possible. If documentation is added after current shift, pharmacist should communicate this to pharmacy leadership team as an escalation.

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POLICY/PROCEDURE

SUBJECT: PHARMACIST DOCUMENTATION AND ESCALATION PROCESS

REFERENCE:

DEVELOPED BY: Pharmacy Policy & Procedure Committee

ORIGINAL ISSUE DATE: December 17, 2018

REVIEW/REVISION DATES:

REPLACES:

REVIEWED BY: Pharmacy Policy & Procedure Committee

APPROVAL FOR IMPLEMENTATION BY: Janet Whittey (Chief Pharmacy Officer)
Signature on File

DATE: 12/17/2018

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SUBJECT: PHARMACIST DOCUMENTATION AND ESCALATION PROCESS

Addendum:

Pharmacy Escalation Handoff Form

Situation		
Background	**Patient Info:** **Prescriber Involved:** **Nurse Involved:**	**Summary:**
Assessment		
Recommendation		

☐ **URGENT - VOICE #**_____ ☐ **Non-Urgent**

Pharmacist Name: _____

Date of Escalation: _____

Person who was contacted for Escalation:

_____

RETURN COMPLETED FORM TO SITE CLINICAL COORDINATOR

Pharmacy Leader Follow up:

Date:_____

Attachment C

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: PALLIATIVE VENTILATOR

DEPARTMENT OVERSIGHT AND MAINTENANCE: Palliative Care Services

POLICY:
Palliative Ventilator Withdrawal (PVW) is the provision of comfort measures for a seriously ill patient for whom continuing mechanical ventilation has been determined to be clinically inappropriate or unwanted by patient.

RESPONSIBLE PERSONS:
Critical Care Units, Acute Palliative Care Units, Physicians, Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Palliative Medicine Consult Team, Pharmacy, Chaplaincy, Respiratory Services

PROCEDURE:
Initial Guided Discussion to Establish a Plan

1. **Review the clinical picture.**
2. **Establish that goals/expectations of PVW are unified.**
3. **Review the plan with the attending physician or critical care physician, other involved physicians, nurses and therapists.**
4. **Consult with system Ethics Committee as needed.**

Follow-Up Discussion to Implement the Plan

1. **Clarify the DNR status and the rationale for not re-intubating.**
2. **Identify treatments to be continued and those treatments to be discontinued.**
3. **Determine the patient/family decision maker's understanding of what will happen after extubation.**
4. **Review the palliative management of symptoms likely to occur during PVW**
5. **Determine when the PVW will occur and if the patient will remain in the ICU or be transferred to the APCU.**
    - **Allow a minimum of one hour after PVW before transferring to APCU**
    - **Provide seamless hand-off of care through communication and collaboration between transferring and receiving units**
6. **Determine who will be present during the PVW.**
7. **Discontinue medications that require ventilator support, including but not limited to, paralytic agents, Versed, propofol**
8. **After discontinuation of above medications, confer with pharmacy regarding the length of time needed prior to extubation, to ensure discontinued medications are no longer active.**

Immediately Prior to PVW

1. **Facilitate private time for patient and family**
2. **Offer the presence of a spiritual/religious professional**

Implementation of Symptom Management Medication Orders

1. **Physician, APRN, and/or PA is required to utilize Palliative Ventilator Withdraw (PVW) PowerPlan**

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POLICY/PROCEDURE

SUBJECT: PALLIATIVE VENTILATOR

2. Physician, APRN, and/or PA must electronically enter Power-Plan orders. No PVW orders may be verbally entered by RN.

3. If there is a clinical indication for medication dosing outside of the Power-Plan, or a medication not in the Power-Plan, the physician, APRN and/or PA must obtain approval from the Critical Care Medical Director and document the medication dosing approved and by whom:
    - If Critical Care Medical Director unavailable, obtain approval from Palliative Physician if they are involved.
    - If palliative team is unavailable, or not involved, obtain approval from Vice President of Medical Affairs (VPMA).
    - If a clinical provider does not utilize the Palliative Ventilator Withdrawal Power Plan in patients who are being treated accordingly, nursing staff should first remind the provider of the requirements of the Palliative Ventilator Withdrawal Policy. If the provider continues to decline to use the Power Plan, the campus specific VPMA should be contacted immediately and notified of the situation
4. Physician, APRN, and/or PA or RN may not administer PVW Power-Plan medications until medications reviewed and verified by pharmacy.
5. Discontinue unnecessary monitors such as ventilator alarms, cardiac monitors, blood pressure monitors, and pulse oximetry.
6. Medications for symptom management will be ordered as medically indicated.

7. Ventilator will be discontinued and the endotracheal tube (ETT), if present, will be removed by the physician, APRN, and/or PA, respiratory therapist, or RN.

8. Patient's response to medications in managing dyspnea and anxiety will be reviewed.
9. Post Palliative Ventilator Withdrawal: When death occurs
    - Provide privacy and support for family.
    - Make referrals for bereavement support as appropriate.

Post Palliative Ventilator Withdrawal: If patient resumes respirations

1. Continue to monitor and provide comfort measures.
2. Identify appropriateness for transfer to APCU.

REFERENCE:

Chan, J.D. et.al. (2004). Narcotic and Benzodiazepine Use After Withdrawal of Life Support. Chest, 126(1), 286-293.

Huynh TN, Walling AM, Le TX, et al. Factors associated with palliative withdrawal of mechanical ventilation and time to death after withdrawal. Journal of Palliate Medicine 2013; 16:1368.

Robert R, Le Gouge A, Kentish-Barnes N, et al. Terminal weaning or immediate extubation for withdrawing mechanical ventilation in critically ill patients (the ARREVE observational

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: PALLIATIVE VENTILATOR

study). Intensive Care Med 2017; 43:1793.

DEVELOPED BY: Palliative Care Services ORIGINAL ISSUE DATE: 3/04

REVIEW/REVISION DATE: 4/05, 2/07, 6/09, 1/14, 5/17, 12/18

REPLACES: P/P *

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: PALLIATIVE VENTILATOR

REVIEWED BY:

Martha Reigel, MD, VPMA St Ann's 12/10/18
Mark Hackman, MD VPMA Mount Carmel East 12/10/18
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APPROVAL FOR IMPLEMENTATION BY:

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Attachment D

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: MEDICATION ORDERS

DEPARTMENT OVERSIGHT AND MAINTENANCE: Administrative

POLICY:

1. Medication orders for patients are written on the prescriber's order form or via electronic order entry by the prescriber, or physician agent (employed by physician) per applicable law.
   a. Any hand-written or electronically entered medication order that presents with an unapproved abbreviation will not be accepted and must be clarified with the prescriber; a new order must be written.

2. Orders shall be forwarded to the pharmacy on a regular basis.

3. The Pharmacy processes medication orders for hospitalized patients prescribed by credentialed providers (including physicians, residents, interns, medical staff, physician assistants, APRN). A physician must countersign all medication orders prescribed by medical students before they are filled by the hospital pharmacy.

4. Before dispensing or removing medications from floor stock, or from an automated dispensing machine, a pharmacist reviews all medication orders unless a licensed independent practitioner controls the ordering, preparation and administration of the medication or when a delay could cause harm to the patient in an urgent situation (including sudden decline of a patient's clinical status).

5. At a minimum, the following patient information is available to those colleagues/prescribers involved in medication management:
   a. The patient's age
   b. The patient's sex
   c. The patient's current medications
   d. The patient's diagnoses, co-morbidities, and concurrently occurring conditions
   e. The patient's relevant laboratory values
   f. The patient's allergies and past sensitivities
   g. Height and weight
   h. Pregnancy and lactation status is also available as appropriate

PROCEDURE

1. REQUIRED ELEMENTS OF A COMPLETE ORDER:
   a. A medication order contains the patient name, date and time of order, the drug name, dosage when applicable, frequency, route and prescriber's signature. The order may also contain medication strength or concentration, when applicable, and quantity and/or duration as applicable. (This includes verbal and telephone orders)
      1. Oxygen is considered a medical gas and a complete order must contain medical gas (oxygen), mode of therapy (nasal cannula, BiPAP, etc.) and dosage (liter flow).
   b. Generic names or brand names are acceptable for medication orders.
   c. The indication for use is required for any as needed or "PRN" medication.

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: MEDICATION ORDERS

d. Orders to "titrate" (increasing or decreasing a dose in response to the patient's status) need to have specific parameters prescribed, e.g., "a heart rate below...," "a diastolic blood pressure above..." (Not applicable to hospice)
   1. The order must specify the sequence of medication titration and discontinuation. If there is more than one medication with the same titration parameter(s) and infusing simultaneously.
   2. The order must include an objective parameter use to titrate the medication including the endpoint.

e. All orders for intravenous, oral liquids, and compounded medications for the neonatal/pediatric population will be reviewed and verified using a neonatal/ pediatric reference. Weight-based dosing will be used for all medications requiring weight-based dosing.

2. TRANSCRIPTION OF MEDICATION ORDERS:
   a. All medication orders will be entered onto the patient's medication administration record (MAR). A copy of the prescriber's order will be sent promptly to the pharmacy when applicable. The RN will reconcile the prescriber order with the MAR.
   b. Any printed/paper prescriber's order sheets must be labeled with at least the patient's name and date of birth. No medications will be dispensed by the pharmacy without a valid medication order, except in emergency situations when delay may cause patient harm.
   c. Medication orders must have the following information on the MAR:
      1. Start date of the order
      2. Name of medication
      3. Dose of medication
      4. Route of administration
      5. Administration times – military time
      6. Stop date, if appropriate
      7. PRN reason (symptoms for which a PRN dose is to be administered), if written as PRN.
      8. Dosage form of the medication
      9. If a liquid dosage form is used, the dose should be expressed in both milligrams (or grams) and the volume to be administered (not necessary for antacids or topical throat sprays).
   d. Any changes in patient information such as newly identified allergies, additional diagnoses, etc. will be provided to the pharmacy and documented so that the medication regimen may be reviewed.

3. PROCESSING OF AN ORDER:
   a. Upon receipt in the pharmacy, the medication order is reviewed and verified by the pharmacist against the patient's profile for the following information before releasing the medication order for dispensing:
      1. Patient's allergies or sensitivities
      2. Existing or potential interactions between the medication ordered and food and medications the patient is currently taking (drug-drug interaction or drug-

food interaction)
3. Appropriateness of the medication, dose, frequency and route of administration
4. Current or potential impact as indicated by laboratory values
5. Over-utilization or under-utilization
6. Therapeutic duplication
7. Drug-disease state contraindication
8. Abuse/misuse
9. Inappropriate duration of treatment

b. The medication order shall be entered into the patient's medication profile. The medication profile is available and accessible by all staff responsible for the patient's care.

c. The medication profile contains:
1. Patient's name
2. Physician's name (attending)
3. Room number
4. Drug and/or food allergies
5. Diagnosis/complaint
6. Age (or birth date)
7. Sex
8. Current medications

d. Information about the patient's recreational and/or use of illegal drugs, misuse of prescription medications, use of investigational drugs, creatinine clearance values for patients 65 years or older, height and weight for dosage calculation, and body surface area for patients undergoing chemotherapeutic regimens, and home supplies of over the counter (OTC), vitamins and herbal products may be used to assess the medication order.

e. Upon verification that the medication order is appropriate for the patient, the medication will be prepared for dispensing. A minimum supply of medications sufficient until the next medication exchange shall be dispensed to meet patient need. Labels affixed to a manufacturer's container (e.g. ophthalmic drops) should not cover up vital information on the manufacturer's label. The prepared medication shall be checked by a pharmacist or robot technology before being delivered to the patient care area. All medications dispensed shall contain a minimum of the name of the medication, dosage, and expiration date. Any required precautionary labels shall be included.

f. After sending the initial medication supply, the order shall be evaluated to determine if subsequent doses will be needed. A sufficient supply of medications shall be placed in the appropriate secured medication area. Medications are dispensed in quantities which minimize diversion yet are still consistent with patient needs.

g. Drugs dispensed from the pharmacy shall have the following information:
1. Patients' last name, first name, and room number
2. Drug name, strength, and diluent (if applicable).

h. When applicable, the following will be included:
1. Beyond use dating (if other than manufacturer's expiration date) – Beyond use date refers to the date in which it is no longer safe to administer this product.

MOUNT CARMEL
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SUBJECT: MEDICATION ORDERS

2. Expiration time when expiration occurs in less than 24 hours

4. STANDARD ADMINISTRATION TIMES:

Daily	0900
BID –Twice a day	0900, 2100
Q12h – Every twelve hours	0900, 2100
TID – Three times a day	0900,1400,2100
Q8h – every eight hours	0800, 1400, 2200
QID – four times a day	0900, 1300, 1700, 2100
Q6h – every six hours	0600, 1200, 1800, 2400
QHS – every hour of sleep – every bedtime	2100
ACHS – before meals and at bedtime	0730, 1130, 1630, 2100
PCHS – after meals and at bedtime	0830, 1230, 1730, 2100

a. Medication orders will be scheduled for administration at standardized routine times unless alternate times are specified in the order.
b. Neonate orders are not subject to standard administration times.
c. Administration of medications that have special administration considerations may be scheduled by a pharmacist to ensure optimal drug delivery such as medications timed to be given with or without meals or food, medications not to be given concurrently, hypoglycemics given before meals, avoiding diuretics prior to bedtime, etc. The administration times of intravenous antibiotic regimens may be scheduled by the pharmacist to facilitate multiple intravenous therapies. Pharmacy consultation orders may necessitate use of non-standard times. Other exceptions to standard medication times may be necessary to order to comply with hospital initiatives and programs.
d. Pharmacist will use professional judgment regarding adjusting start times for medications. The nurse will use professional judgment regarding administration of the first dose of medication based on information supplied by the patient.

5. BLANKET/RESUME ORDERS:
   a. The use of blanket/resume orders for medications, such as "continue previous meds", "give home meds", "resume preoperative meds", and "discharge on current meds", are not acceptable orders.
   b. The prescriber must be contacted by either nursing or pharmacy to clarify the blanket/resume order.

6. CLARIFYING MEDICATION ORDERS:
   a. It is the responsibility of the prescriber, pharmacist and/or the nurse to assure that medication orders are complete to promote the safe use of the medication. Pharmacist intervention may be necessary to document the intent of the prescriber and/or assist with adjusting the proposed therapy to obtain the intended results.
   b. A medication should be clarified prior to being dispensed if the potential exists for patient harm or lack of therapeutic effect due to problems with legibility or lack of order completeness.

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SUBJECT: MEDICATION ORDERS

c. There are times when specific patient conditions warrant administering medications outside of the usual dosing parameters (i.e. obesity, pain control in tolerant patients, palliative care). These medication orders require pharmacist review to determine if it is acceptable to administer; a reference will be required to support its use (i.e. Lexicomp, Up-to-date, primary literature). If a reference cannot be located or provided by the prescriber/pharmacy, the RN may not administer the medication unless special approval is received. All medication order requests outside of the usual dosing parameters should be vetted through pharmacy leadership; pharmacy leadership will coordinate appropriate approval path based on the medication in question. If the medication is delayed or cannot be administered, RN must notify the ordering LIP, document that the medication was not administered, and a new order will need to be written.

d. If a situation is identified that requires clarification, the pharmacist and/or nurse must contact the prescriber as soon as possible to determine the intent of the medication order.

e. Attempts to contact the prescriber must be documented.

f. If the prescriber cannot be contacted/reached within a reasonable amount of time, or there is still a safety concern after discussion with prescriber, see the chain of command policy for next steps.

g. The pharmacist must communicate any delays in therapy to the nurse caring for the patient or charge nurse.

h. If any change is necessary to an existing order, a new order must be obtained.

7. DISCONTINUING OR CHANGING A MEDICATION ORDER:
   a. When a medication is discontinued, the medication discontinuation will be reflected on the MAR and doses returned to the Pharmacy.
   b. Changes in medication therapy should be addressed in the same manner as medication discontinuation. The previous order will need to be discontinued and a new medication order provided. If the order on the pharmacy medication profile can be changed/modified in a manner that allows for an audit trail to the original order, this method can be performed.
   c. Once the changed medication order is prepared, it must be checked as if a new order.
   d. Medication can be discontinued per a previous active order using the order communication type of "Department" when a new order supersedes a previously dated active order. If there is a question about the appropriateness of discontinuing the previous order, the prescriber should be contacted. (Trinity Health "Management of Electronic Orders" system policy # 17-05).

8. CONCENTRATION OF AN INTRAVENOUS MEDICATION:
   a. Refer to IV Guidelines for approved concentrations of IV medications.
   b. When an increased or decreased concentration is desired and the drug has two approved concentrations, the prescriber can order to maximize or minimize the concentration of the drug.

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c. When an increased or decreased concentration is desired and the drug has more than two approved concentrations, a prescriber must specify the specific concentrations to be used.

9. ORDER PRIORITIY:

Order Priority	*Timeframe*
STAT	To be administered within 30 minutes*
ASAP	To be administered within 60 minutes
Routine	To be administered within 2 hours or next scheduled time

*STAT medication orders – to include sequential antibiotics which needs to have the initial Antibiotic administered within 30 minutes. For drugs that must be mixed, i.e., large volume intravenous (IV) fluids and IV piggyback/syringe administration, the timeframe of administration is within 60 minutes.

a. STAT medications:
This designation is reserved for highest priority orders (i.e. Life threatening situations). Although STAT orders have a maximum turnaround time of 30 minutes, in many cases they need to be filled immediately, depending on the situation. The prompt distribution of the medication from the pharmacy is essential in these cases. When a prescriber's order for a medication is ordered "STAT," it should be processed immediately. The nurse and the pharmacist decide upon the best method of delivery to avoid delay. Any written orders should be retrieved and reviewed as soon as possible by the pharmacy.

b. ASAP medications (as soon as possible):
This designation is meant for situations that are not life-threatening, but where completion of the order will have significant clinical or throughput implications. Historically, the term "now" has also been used, and this should also be interpreted to be in the ASAP order priority.

c. Routine medications:
This designation is for non-urgent orders

10. MULTIPLE ADMINISTRATION ROUTES:
If multiple administration routes are prescribed, the following sequence should occur:
1. Ascertain that all options are viable for the patient (i.e. Ability to swallow, level of consciousness, presence of IV access, presence of nausea and vomiting)
2. The IM route is the least preferable for most medications due to patient discomfort and fluctuations in absorption
3. If rapid response is needed (i.e. severe pain level, new post-operative patient) consider absorption time of IV versus oral administration
4. Consider patient preference and effectiveness of previously administered doses.

11. PRN MEDICATION ORDERS:

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: **MEDICATION ORDERS**

The pharmacist is responsible for assuring appropriate and safe prescribing procedures are followed. The frequency with which "as needed" medications may be administered must be monitored to avoid interactions with other medications and to avoid exceeding maximum recommended dosing.

a. All PRN medication orders must state frequency and indication for use of the PRN medication prior to administration.
b. If two or more PRN medications for the same indication are ordered, the order of administration or parameters must be clearly stated.
   1. Example for antiemetic medication
      Promethazine (Phenergan) 6.25 mg IV every 6 hours as needed for nausea. If nausea is unrelieved by Promethazine, give Ondansetron (Zofran) 4 mg IV every 24 hours as needed for nausea.
   2. Example for pain medication
      Acetaminophen (Tylenol®) 325 mg 1-2 tablet(s) orally every 4 hours as necessary for mild pain
      Hydrocodone 5 mg/Acetaminophen 325 mg (Norco®) 1-2 tablet(s) orally every 4 hours as necessary for moderate pain
      Morphine sulfate 2 mg IV every 4 hours as necessary for severe pain
c. PRN pain medications

Patient's Pain Score	PRN indication
1 to 3	Mild Pain
4 to 6	Moderate Pain
7 to 10	Severe Pain

12. RANGE ORDERS: (Not applicable to Hospice)
   a. When an order is written that includes a dosage range, the instructions on how the nurse determines what dose to administer should be included in the physician's order. In the absence of specific instruction, the nurse will administer the medication according to the following guidelines: (Refer to Administrative Policy: Pain Management). Refer to Patient's Pain Score table in # 11c.

Patient's Pain Score	Action to be taken
1 to 3 (mild pain)	Administer lowest dosage in the prescribed dosage range
4 to 6 (moderate pain)	Administer the lowest dosage that has been effective. If necessary, there will be escalated upward, not to exceed the upper limit of the prescribed dosage range
7 to 10 (severe pain)	Administer the highest dosage in the prescribed dosage range
10 (Pain unresolved after administering the highest dose)	Contact the prescriber for reassessment of the patient's needs
10 (acute pain, new onset, unknown etiology)	Contact the prescriber for reassessment of patient's needs

b. When a medication is ordered that includes a range of frequency (e.g. every 4 – 6 hrs), the order will be interpreted as the shortest interval (e.g. every 4 hours).

Range in Frequency	Transcribed on the MAR
Every 3-4 hours	Every 3 hours
Every 6-8 hours	Every 6 hours
Morphine 2-4mg IV every 4-6 hour PRN pain	Morphine 2-4mg IV every 4 hour PRN pain

c. For other medications (i.e. anti-pyretics, anti-emetics, laxatives, antacids, stool softeners, anti-flatulence, sedatives, hypnotics, sleep aids, antihistamines) give the lowest dose range prescribed and reassess for desired effects as appropriate for the medication. If symptomatic relief is not obtained, the subsequent doses should be administered.

13. STANDING ORDERS: (the same as "protocol")

a. Standing orders are defined as written instruction to administer a medication in circumstances specified without a prescription. These are not to be confused with *pre-printed* orders.
Standing order/Protocol is further defined as:

1. A definitive set of treatment guidelines that include definitive orders for drugs and their specified dosages which may have been authorized by a prescriber (as defined by Administrative Code 4729-5-15) and have been approved by the state board of pharmacy to be used by certified or licensed health care professionals when providing limited medical services to individuals in an emergency situation when the services of a prescriber are not immediately available, or;

2. A definitive set of treatment guidelines that include definitive orders for drugs and their specified dosages which have been authorized by a prescriber (as defined by Administrative Code 4729-5-15) and have been approved by the state board of pharmacy to be used by certified or licensed health care professionals when administering biologicals or vaccines to individuals for the purpose of preventing disease; or

3. A definitive set of treatment guidelines that include definitive orders for drugs and their specified dosages which have been authorized by a prescriber (as defined by Administrative Code 4729-5-15) and have been approved by the state board of pharmacy to be used by certified or licensed health care professionals when administering vitamin K for prevention of vitamin K deficient bleeding in newborns; or

4. A definitive set of treatment guidelines that include definitive orders for drugs and their specified dosages which have been authorized by a prescriber (as defined by Administrative Code 4729-5-15) and have been approved by the state board of pharmacy to be used by certified or licensed health care

professionals when administering erythromycin for prevention of ophthalmia neonatorum; or

5. A definitive set of treatment guidelines that include patient specific and dose specific orders for the administration of a specific drug that have been authorized by a prescriber to be used when the services of that prescriber are not immediately available. The state board of pharmacy must approve the treatment guidelines prior to implementation.

b. Appropriate use of standing orders/protocols:
   1. A protocol may only be used in a true emergency or for reasons outlined above.
   2. The protocol from the authorized prescriber must specifically define the intended patient population; list the drug name and strength, and for purposes of emergency protocols, give specific instructions on how to administer the drug, including dose and frequency; for purposes of biologicals or vaccines, give specific instructions for use of the drug.

c. The use of standing orders/protocol must be documented as an order in the patient's electronic health record (EHR), as soon as appropriate.

d. Standing orders/protocols are approved by the medical staff.

e. Standing orders/protocols cannot be altered without a prescriber's order.

f. The only standing orders/protocols used at Mount Carmel are outlined in the chart below:

Drug	Intended Patient Population	Purpose	Order Details/Comments
Erythromycin 0.5% eye ointment	Newborns	Prevention of ophthalmia neonatorum	1 application to each eye x1 within first hour after birth
Phytonadione 1 mg injection	Newborns	Prevention of Vitamin K deficient bleeding in newborns	1 mg IM x1 within first hour after birth
Influenza Vaccine	Inpatients	Disease prevention	0.5 ml IM x1
Pneumococcal Vaccine	Inpatients	Disease prevention	0.5 ml IM x1
Influenza Vaccine	Mobile Coach/ Street Medicine patients	Disease prevention	0.5 ml IM x1
Pneumococcal Vaccine	Mobile Coach/ Street Medicine patients	Disease prevention	0.5 ml IM x1
Tdap vaccine	Mobile Coach/ Street Medicine patients	Disease prevention	0.5 ml IM x1

g. Prior to administration of a vaccine, the patient will receive education regarding the vaccine and the RN will document that education was provided in the EHR.

14. HOLDING A MEDICATION:

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: MEDICATION ORDERS

a. If an order is written to hold a dose of medication based upon specified conditions, the order will remain active. (example: hold for SBP less than 120, hold for HR less than 60, hold single dose of ...)
b. If an order is to hold a medication with no criteria to restart, the medication will be discontinued and a new order will be required.

15. AUTOMATIC STOP ORDERS:
    a. Some medications have strict recommendations not to exceed a certain length of therapy. Formulary medications with hard stops include:
        1. Oseltamivir- 5 days
        2. Ketorolac-5 days
        3. Pantoprazole injection- 3 days
    b. Other medications have a soft stop of 30 days unless a specific time or number of doses has been prescribed.

16. Weaning/Tapering medication orders must include the process for weaning/tapering the amount the dose is to be decreased for each step and the frequency (not applicable to Hospice). The order must specify the sequence of medication titration and discontinuation if there is more than one medication with the same titration parameter(s) and infusing simultaneously.

17. Orders for compounded medications or medication mixtures not commercially available will be accepted by pharmacy. Medications will be compounded according to Pharmacy's standardized approved formulas unless otherwise specified in prescriber's order.

18. ELECTRONIC ORDER MANAGEMENT:
    a. There are special considerations when managing electronic medication orders. It is important for healthcare professionals to understand the electronic health record (EHR) functionality and to use it correctly.
    b. There are various Medication Order Communication types in EHR. Some communication types are designed for use by particular healthcare professionals. Some communication types require a physician signature while others do not. See Addendum A which outlines the proper use of Medication Order Communications.
    c. Within Medication Manager (the Pharmacy part of EHR), pharmacists may take certain profile actions on medication orders. See Addendum B which outlines the proper use and purposes of various profile actions.

19. OUTPATIENT PRESCRIPTIONS GENERATED FROM ELECTRONIC HEALTH RECORD(EHR):
    a. All non-controlled substances prescriptions created in the EHR by a LIP must include the following for (pursuant of OAC 4729-5-30):
        i. Issue date
        ii. Full name, professional title, and address of the prescriber
        iii. Full name, residential address of the patient
        iv. Drug name and strength
        v. Quantity to dispense

vi. Appropriate and explicit directions for use
vii. Number of refill, maximum # of 11.
viii. Printed outpatient prescriptions need to be manually signed on the day issued by the prescriber in the same manner as he/she would sign a check or legal document or other approved method of positive identification.

b. All controlled substances prescriptions created in the EHR by an LIP must include the following in addition to the non-controlled substances requirements:
   i. Quantity to dispense in numerically AND alphabetically.
   ii. Number of refill,
      a. Category II, no refill.
      b. Category III and IV, maximum # of 5.
      c. Category V, maximum # of 11.
   iii. Drug Enforcement Administration (DEA) number.
   iv. Diagnosis code
c. The "agent" of a prescriber is defined as a person who has an employer-employee relationship with the prescriber, regardless whether controlled or non-controlled substances.
d. Only LIPs or the prescriber's agent are authorized to create an out-patient prescription using the EHR prescription writer.
e. Hospital employed colleagues are not permitted on behalf of a prescriber to create and print or fax, create and transmit electronically or call to a pharmacy a verbal prescription as an agent of the LIP.
f. In the event an electronically generated prescription needs voided after electronic transmittal, the LIP needs to contact the pharmacy where the prescription was transmitted electronically, in addition to voiding the prescription in the EHR.
g. In the event a prescription printed and manually authenticated by an LIP needs to be voided, then "void" needs written across the prescription. Ensure the voided prescription is placed with other health care documents for submission into the EHR. This action is completed by LIP, a pharmacist or nurse.
h. Preferred method for generating out-patient prescriptions is through the electronic ordering process (e-prescribe) to avoid diversion opportunities, with exceptions being, no preferred pharmacy identified by patient or EHR downtime.

RESPONSIBLE
PERSONS: Pharmacy, Nursing, Prescribers

REFERENCES: Administrative P/P "Physician Orders"
MCHS IV Guidelines

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: **MEDICATION ORDERS**

REVIEW/REVISION DATES: 8/08, 11/08, 2/09, 7/09, 2/10, 6/10, 9/10, 12/10, 4/11, 8/11, 4/12, 10/12, 2/13, 8/14, 9/14, 2/16, 9/16, 8/17, 1/19

REPLACES: Administrative Policy/Procedure "Medication Orders"

REVIEWED BY:			
	Pharmacy Policy and Procedure Team		1/10/19
	Administrative Policy Team	via email vote	1/16/19

Janet Whitley 1/16/19
Chief Pharmacy Officer Date

APPROVED FOR IMPLEMENTATION BY: Mount Carmel Leadership Accreditation Council
DATE: via email vote 1/16/19

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: MEDICATION ORDERS

ADDENDUM A: Proper use of Medication Order Communication Types in Cerner

Communication Types as displayed in Cerner	Description	Entered by licensed healthcare professional as allowed within their respective legal scope of practice.	Requires physician signature
AHP Co-sign	Used by health care professionals who are not licensed or credentialed to independently prescribe.	Anesthesia Assistant Certified Registered Nurse Anesthetist	Yes Dependent on scope of Prescriptive authority
AHP	Orders entered from within Surgical Anesthesia Module (SAM).	Anesthesiologist Certified Registered Nurse Anesthetist (SAM med orders)	No
Department	Used when there is an approved policy and or guidelines to manage a patient's medication therapy.	Dietician (enteral therapy related products ONLY) Pharmacist Respiratory therapist- modality of respiratory medications 0.9%NaCl/heparin flushes all users with IV line management as scope of practice Vitamin K 1mg/0.5ml inj and Erythromycin ophthalmic oint 0.5% 1 gram Discontinuation(s) ONLY per this policy for all users with medication Management as scope of practice	No
Med given in error, No order	One time medication order when a medication is given to a patient without an order and in error. The errors should be documented in the event reporting system.	Cardiovascular Sonographer Radiology Technologist Registered Nurse Respiratory Therapist	No
Phone/Rep& confirmed –	Order received over the phone. The process must include entering the order into the system and reading it back to the prescriber who confirms it has been correctly received.	Advanced Practice Nurse Cardiovascular Sonographer Dietician Pharmacist Physician Assistant Radiology Technologist Registered Nurse Respiratory Therapist	Yes
Prescribing Student co-sign	Any student (Med, PA, APRN) with the authority to prescribe enters the order. (Before the orders are processed and visible to other healthcare professionals requires co-signature by prescriber)	Student with medication ordering as scope of practice	Yes

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SUBJECT: MEDICATION ORDERS

Communication Types as displayed in Cerner	Description	Entered by licensed healthcare professional as allowed within their respective legal scope of practice.	Requires physician signature
Protocol	No use of this communication type for medications in the Mount Carmel System		Yes
Transcribed Verbal	Orders entered into the system when a verbal order has been written in the health record by an authorized health care professional, though not entered into the system by the person. Primarily used to enter orders after a downtime/disruption. **Note:** If order entered electronically by healthcare professional other than pharmacist, pharmacist must have source document to check order entry.	Cardiovascular Sonographer Dietician Pharmacist Radiology Technologist Registered Nurse Respiratory Therapist	Yes
Transcribed Written	Provider electronically enters (writes) an order into the system OR documents and signs written orders on physician ordering paper or paper prescription. **Note:** If order entered electronically by healthcare professional other than pharmacist, pharmacist must have source document to check order entry.	Cardiovascular Sonographer Dietician Pharmacist Radiology Technologist Registered Nurse Respiratory Therapist	No
Verbal Repeated & confirmed	Order verbally received and entered into the system. The process must include entering of the order into the system and reading it back to the prescriber who confirms it has been correctly received	Advanced Practice Nurse Cardiovascular Sonographer Dietician Pharmacist Physician Assistant Radiology Technologist Registered Nurse Respiratory Therapist	Yes
Written	Order entered electronically or written/signed on paper by a prescriber.	Prescriber with prescriptive Authority	No

The following communication types are not to be used by pharmacists in MedManager: Planned order, Nursing Intervention

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: **MEDICATION ORDERS**

Proper Use of Medication Profile Actions

Profile Action	Definition of Profile Action
(none)	bypass actions selected in error
Accept	Verifies order without order review. Appropriate to use for orders that have been discontinued in Powerchart by prescriber/agent of the prescriber
Cancel	cancel an un-dispensed order for which charges were credited all future tasks (doses) on MAR will be removed and overdue tasks (un-administered doses) remain on the MAR
Copy	use an existing discontinued order as a template to create a new order
Discontinue	discontinues an order and removes future tasks (doses) from MAR and overdue tasks (un-administered doses) remain on the MAR Use this function when there are no safety concerns for overdue tasks (un-administered doses) remain on the MAR
History	review all action and dispensing history for an order
Inquire	review details for an existing order
Intervene	intervention documentation NOT functional
Label	generate labels as required
Modify	allows certain fields of the order to be changed.
Pass	allows for label to print for a LOA
Reject	rejection of an order means there is a concern with the order (drug, dose, frequency) No order details will be shown at time of rejection. Pharmacy must contact the physician for follow up
Renew	renew an order that has an existing stop date for a new period
Reschedule	adjust the administration times
Resume	restart an order for an existing stop date for a new period
Suspend	places order in an On Hold status
Verify	confirm that the product entered for a patient is correct
Void	a new order was entered on the wrong patient, wrong drug, or a new order needs to be changed. This action removes all overdue tasks (un-administered doses) and future doses

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: PALLIATIVE VENTILATOR

DEPARTMENT OVERSIGHT AND MAINTENANCE: Palliative Care Services

POLICY:
Palliative Ventilator Withdrawal (PVW) is the provision of comfort measures for a seriously ill patient for whom continuing mechanical ventilation has been determined to be clinically inappropriate or unwanted by patient.

RESPONSIBLE PERSONS:
Critical Care Units, Acute Palliative Care Units, Physicians, Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Palliative Medicine Consult Team, Pharmacy, Chaplaincy, Respiratory Services

PROCEDURE:
Initial Guided Discussion to Establish a Plan

1. Review the clinical picture.
2. Establish that goals/expectations of PVW are unified.
3. Review the plan with the attending physician or critical care physician, other involved physicians, nurses and therapists.
4. Consult with system Ethics Committee as needed.

Follow-Up Discussion to Implement the Plan

1. Clarify the DNR status and the rationale for not re-intubating.
2. Identify treatments to be continued and those treatments to be discontinued.
3. Determine the patient/family decision maker's understanding of what will happen after extubation.
4. Review the palliative management of symptoms likely to occur during PVW
5. Determine when the PVW will occur and if the patient will remain in the ICU or be transferred to the APCU.
    - Allow a minimum of one hour after PVW before transferring to APCU
    - Provide seamless hand-off of care through communication and collaboration between transferring and receiving units
6. Determine who will be present during the PVW.
7. Discontinue medications that require ventilator support, including but not limited to, paralytic agents, Versed, propofol
8. After discontinuation of above medications, confer with pharmacy regarding the length of time needed prior to extubation, to ensure discontinued medications are no longer active.

Immediately Prior to PVW

1. Facilitate private time for patient and family
2. Offer the presence of a spiritual/religious professional

Implementation of Symptom Management Medication Orders

1. Physician, APRN, and/or PA is required to utilize Palliative Ventilator Withdraw (PVW) PowerPlan

Attachment E

ZERØHARM
STARTS WITH YOU

HIGH RELIABILITY ORGANIZATION

December, 2018

BECAUSE OF YOU

MOUNT CARMEL

A Member of Trinity Health

REFLECTION

"OUR LIVES BEGIN TO END, THE DAY WE BECOME SILENT ABOUT THINGS THAT MATTER."

"THE ULTIMATE MEASURE OF A MAN IS NOT WHERE HE STANDS IN MOMENTS OF COMFORT AND CONVENIENCE, BUT WHERE HE STANDS AT TIMES OF CHALLENGE AND CONTROVERSY."

-MARTIN LUTHER KING JR.

AGENDA

- S.B.A.R. - High Risk Medication Dosing
- ZeroHarm Culture Principals
  - High Reliability Organizations
  - Behavior Expectations/Error Prevention Tools
  - Power Gradient
- Scope of Practice/Nursing - Pharmacy
- Palliative Care Ventilator Withdrawal Power Plan/Policy
- Pharmacy Review vs. Override
- Verbal Order Policy
- Pain Scale for Intubated Patients
- Documentation

S.B.A.R – High Risk Medication Dosing

Situation: High doses of medication were administered outside of Mount Carmel's IV guidelines.

Background: The Palliative Ventilator Withdrawal policy provides guidance for the provision of comfort measures for a patient for whom continuing mechanical ventilation has been determined to be clinically inappropriate or unwanted by the patient.

Assessment: A review of our opportunities revealed a need for consistency around treatment of palliative patients being terminally weaned from a ventilator.

Recommendation: Provide education to clinicians regarding appropriate comfort care for palliative patients who are being weaned from a ventilator.

ZERØHARM STARTS WITH YOU

SAFETY[1] + QUALITY[2] + PATIENT EXPERIENCE[3] = THE CARE EXPERIENCE

Mount Carmel's care experience plus our staff's engagement are how we deliver on our promise—to put people at the center of everything we do.

Zero is the only acceptable goal
–Because one is too many

ZERØHARM STARTS WITH YOU

Reinforces Behavior Expectations

Emphasizes that each one of us is accountable

Connects to our Because of YOU brand to further strengthen recognition

Consistent way to visually tie together education and communications

WHY? People are at the center of everything we do and that means safety is our first responsibility

GOAL: Eliminate preventable harm throughout our system for patients and colleagues

ZeroHarm – HIGH-RELIABILITY ORGANIZATION

1. ***PREOCCUPATION WITH FAILURE*** – Don't ignore any failure, no matter how small, they think about how things can fail.
2. ***SENSITIVITY TO OPERATIONS*** – Focus on the actual situation and rely on their frontline for the best picture of the situation.
3. ***RELUCTANCE TO SIMPLIFY*** – Don't explain away problems, they ask questions and dig deep to find answers.
4. ***COMMITMENT TO RESILIENCE*** – Never give up even when it's hard, they adapt and bounce back.
5. ***DEFERENCE TO EXPERTISE*** – Recognize that expertise is not based on authority.

S.T.A.R.T

ZERO HARM STARTS WITH YOU

BEHAVIOR EXPECTATIONS	ERROR PREVENTION TOOLS
S SPEAK UP	▶ Clarifying Questions ▶ ARCC it Up (Ask, Request, Concern, Chain of Command)
T TEAMWORK	▶ Cross Check ▶ 5:1 Feedback
A ATTENTION TO DETAIL	▶ STAR (Stop, Think, Act, Review)
R RELIABLE COMMUNICATIONS	▶ Standard Handoffs ▶ SBAR (Situation, Background, Assessment, Request/Recommendation) ▶ 3-Way Repeat & Read-Back using Clarifications
T THINK IT THROUGH	▶ Questioning Attitude using Validate & Verify ▶ Stop the Line

POWER GRADIENT

Geert Hofstede's Power Distance

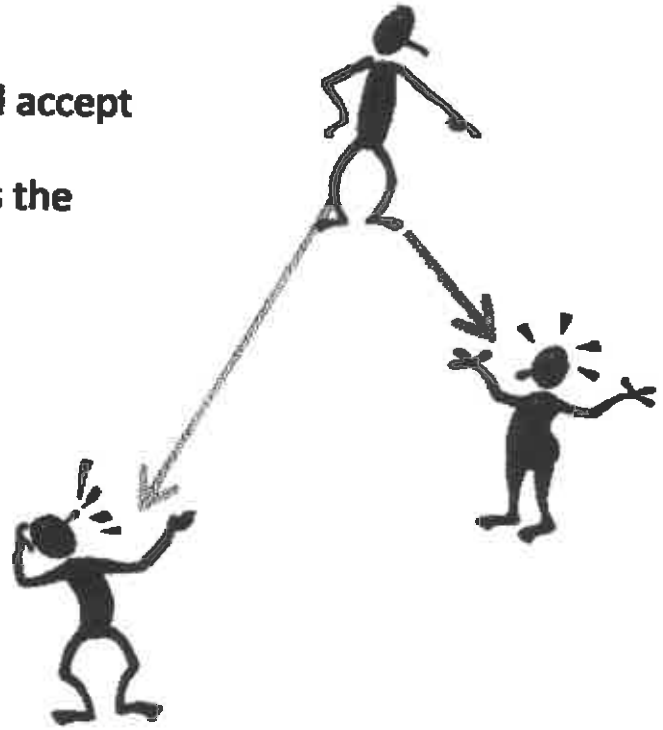
- Extent to which the less powerful expect and accept that power is distributed unequally
- Leads to strong Authority Gradients, which is the perception of authority as perceived by the subordinate

United States

- Moderate to low Power Distance (38th of 50 countries)

In Healthcare

- High between certain professional groups:
- Some Practitioners and nurses
- Some nurses and other clinical staff
- Some leaders and staff



ARCC it Up to escalate concerns

- We all have a responsibility to protect our patients and coworkers from harm.
- If you see or hear something that is a safety issue, escalate your concern in a mutually respectful manner.
- Assert yourself, but don't be aggressive or rude.

Ask a question

Request a change – offer another alternative

Still no response?

Voice a **Concern** – use Safety Phrase: **"I have a concern…"**

If no success,

Escalate up **Chain** of Command

SITUATION

- The Practitioner enters a medication order and pharmacist reviews the order. The nurse is now ready to obtain the medication from Pyxis and realizes that it will take numerous vials to complete the dose. The nurse is concerned about this and tried to clarify the order with the Practitioner but the Practitioner still wants the medication given.
- What should the nurse do?
- ARCC it up

SITUATION

Under the Nurse Practice Act - when clarifying an order, the RN shall, in a timely manner:

1. Consult with an appropriate licensed practitioner;
2. Notify the ordering practitioner when the RN makes the decision not to follow the order or administer the medication or treatment, including the reason for not doing so, and;
3. Document that the practitioner was notified of the decision not to follow the order or administer the medication or treatment, including the reason for not doing so; and
4. Take any other action needed to assure the safety of the patient

WAYS TO ARCC IT UP... DIRECT COMMUNICATION

- SUPERVISOR/CHARGE NURSE/HOUSE SUPERVISOR
- FRONT LINE MANAGER
- DIRECTOR/REGIONAL LEADER
- ADMINISTRATOR ON CALL "Hospital and System" 24x7
- PATIENT SAFETY OFFICER – Katie Barga
- MCW/MCGC EXECUTIVE TEAM
  - Sean McKibben, President
  - Larry Swanner, MD, VPMA
  - Dina Bush, VP/CNO
  - Jeannette Contosta, Director of HR
  - Chellee Hamilton, VP Operations
  - Rosa Shiffman, Quality Business Partner
- System Executive Team
  - Ed Lamb, CEO
  - Mary LaFrancois, Senior VP HR
  - Rick Streck, MD, Chief Clinical Operations Officer
  - Katrina Trimble, VP Compliance and Integrity
  - Dan Hackett, VP Legal
  - Tauana McDonald, Chief Administrative Officer
  - Holly Reardon, VP of Quality
- VOICE REPORTING SYSTEM
- MC/TRINITY INTEGRITY HOTLINE

SCOPE OF PRACTICE NURSING/PHARMACY

- Scopes of practice describes the services that a qualified health professional is deemed to perform, and permitted to undertake – in keeping with the terms of their professional license
- We are held to the American Nurses Association, Nurse Practice Act and State Law, The Joint Commission, Ohio Department of Health, DEA

SCOPE OF PRACTICE NURSING/PHARMACY

Nurses Responsible for:

- Compliance with the American Nurses Association, Nurse Practice Act and State Law, The Joint Commission, Ohio Department of Health, DEA
- Compliance with all documentation requirements of the Ohio Board of Nursing
- Hospital-based Standards and Policies

Pharmacists Responsible for:

- Compliance with the Ohio Board of Pharmacy rules and regulations, The Joint Commission, Ohio Department of Health, DEA, USP, and other Federal requirements
- Medication order prospective drug utilization review per Ohio State Board of Pharmacy
- Compliance with all documentation requirements per Ohio Board of Pharmacy
- Hospital-based Standards and Policies

VERBAL ORDER POLICY

TJC Standard MM.04.01.01 (element A6)

The hospital minimizes the use of verbal and telephone medication orders. (*Departments with 24/7 Practitioner coverage should not use "verbal orders" function with the exception of medications used in emergencies i.e. ACLS)*

MCHS "Practitioner Orders" Policy;

VERBAL OR TELEPHONE ORDERS

Verbal or telephone orders are to be limited and restricted to:

- ❑ Emergent situations.
- ❑ When clinical situations make it impractical for orders to be entered into the EHR or written on the appropriate form for the non-EHR sites.
- ❑ Situations when Practitioners do not have access to remote computer devices or the patient's chart.

PALLIATIVE VENTILATOR WITHDRAWAL POWER PLAN

PATIENT CARE	
ADVISORY: Evaluate need for sedation in the comatose patient. Titrate medications to achieve desired comfort level and sedation prior to removing ventilator.	
ADVISORY: Goal of medication management in withdrawal of support is titration of medication to assure patient comfort. Patient should appear to be resting comfortably with no pain behaviors or grimacing. Consider using heart rate greater than 100 or respirations greater than 30 as objective findings of distress.	
Prepare for withdrawal of ventilator support	
Communication Order Patient Care	Withdrawal ventilator support when level of comfort is within desired limits (no grimacing, no agitation, comfortable respiratory rate (30 breaths/minute or less)
Communication Order Patient Care	For increased distress or agitation administer opioids or anxiolytics as ordered.
Communication Order Patient Care	Organ Procurement Agency must be notified prior to ventilator removal.

PALLIATIVE VENTILATOR WITHDRAWAL POWER PLAN

MEDICATIONS	
EVIDENCE: Guide for Withdrawing Terminal Patients From Ventilator Support, Principle of Double Effect.	
Pharmacy Communication Order	
Morphine (Morphine Inj.)	10 mg, IV Push, Inject Once
Morphine (Morphine Inj.)	1 mg, IV Push, Inject, Q15min, PRN, Shortness of Breath
Morphine (Morphine Inj.)	2 mg, IV Push, Inject, Q1h, PRN, Shortness of Breath
HYDROmorphone (Dilaudid Inj.)	0.5 mg, IV Push, Inject, Q15min, PRN, Shortness of Breath
Morphine 100 mg/100 mL NS (std2)*	Titrate – See Comments, 100 mL, Infusion
Morphine 200 mg/200 mL NS (std2)*	Titrate – See Comments, IV, 100mL
Midazolam (Versed Inj*)	2 mg, IV Push, Inject, Once, ASAP

PALLIATIVE VENTILATOR WITHDRAWAL POWER PLAN

MEDICATIONS	
ADVISORY: Continuous Infusion Rate Should be 50% of Bolus Dose Per Hour	
Versed 50 mg/50 mL NS w/RASS (std2)*	IV, 50 mL, Infusion
LORazepam (Ativan Inj*)	0.5 mg, IV, Iject, Q15min, PRN, Agitation
LORazepam (Ativan Inj*)	0.5 mg, IV, Inject, Q4h, PRN, Agitation
Atropine (Atropine0.1 mg/mL Syringe 10 mL)	0.5 mg, Subcut, Inject, Q1h, PRN

PALLIATIVE VENTILATOR WITHDRAWAL POLICY

- Key Updates to Palliative Ventilator Withdrawal (PVW) Policy
  - Effective 12/12/2018

1. PVW Power Plan **must** be utilized
2. Practitioner **must** electronically enter their own PVW Power Plan orders
3. **No** verbal orders for PVW Power Plan
4. Medication dosing outside of Power Plan, or medications not included on Power Plan, Practitioner **must** obtain approval per policy
5. Practitioner or RN **cannot** administer PVW medications until verified by pharmacy

PYXIS OVERIDE

Joint Commission Standard requires pharmacist review of all medication orders. Two exceptions are allowed:

a. **When a licensed independent Practitioner controls the ordering, preparation and administration of the medication; or**

b. **When a delay would harm the patient in an urgent/emergency situation including sudden changes in a patient's clinical status.**

Examples of appropriate emergency situations:

- Code Blue, Anaphylaxis

Examples of situations that require pharmacist review:

- Palliative Extubation

PYXIS OVERRIDE EXAMPLES

- Override Medications are not to be used for the purpose of non-emergent situations – including Palliative Ventilator Weaning

- Override is appropriate in unplanned emergency situations, such as intubation

CPOT PAIN SCALE

- In the ICU, the Critical Care Pain Observation Tool (CPOT) is used for non-verbal patients

- For non-verbal patients, this is the appropriate tool to use for documentation of patient pain assessment

CPOT PAIN SCALE

Medscape www.medscape.com

Indicator	Description	Score	
Facial expression	No muscular tension observed	Relaxed, neutral	0
	Presence of frowning, brow lowering, orbit tightening, and levator contraction	Tense	1
	All of the above facial movements plus eyelid tightly closed	Grimacing	2
Body movements	Does not move at all (does not necessarily mean absence of pain)	Absence of movements	0
	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements	Protection	1
	Pulling tube, attempting to sit up, moving limbs/ thrashing, not following commands, striking at staff, trying to climb out of bed	Restlessness	2
Muscle tension Evaluation by passive flexion and extension of upper extremities	No resistance to passive movements	Relaxed	0
	Resistance to passive movements	Tense, rigid	1
	Strong resistance to passive movements, inability to complete them	Very tense or rigid	2
Compliance with the ventilator (intubated patients)	Alarms not activated, easy ventilation	Tolerating ventilator or movement	0
	Alarms stop spontaneously	Coughing but tolerating	1
OR	Asynchrony: blocking ventilation, alarms frequently activated	Fighting ventilator	2
Vocalization (extubated patients)	Talking in normal tone or no sound	Talking in normal tone or no sound	0
	Sighing, moaning	Sighing, moaning	1
	Crying out, sobbing	Crying out, sobbing	2
Total, range			0-8

Source: Am J Crit Care © 2006 American Association of Critical-Care Nurses

Documentation Requirements: Practitioner

- Conversation prior to DNR-CC order with family, or POA
- Order for DNR-CC placed in Power Chart
- Post procedure note
- Comprehensive death note

DOCUMENTATION REQUIREMENTS: PHARMACIST

- If a situation is identified that requires prescriber clarification, the pharmacist will document the discussion;
- After discussion and if the pharmacist still has a safety concern, the pharmacist will communicate with prescriber using the safety phrase 'I have a concern and need to escalate this up the chain of command'

DOCUMENTATION REQUIREMENTS: NURSING

- Documentation should reflect (example PVW):
  - Prior to intervention - assessment of patient pain, agitation level, respirations and airway
  - Post intervention – assessment of patient pain, agitation level, respirations and airway to monitor effectiveness of intervention
  - If you identify an order that causes you concern, review your concern with the Practitioner and document expressed concern
  - After discussion, if there is still a safety concern, nurse will communicate with Practitioner the safety phrase "I have a concern and need to escalate this up the chain of command"
  - Family present and support offered to the family/care partner

QUESTIONS

A BEACON OF HOPE...